DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

February 3, 2020

In Reply Refer To: 001B
FOIA Request: 19-09094-F

Austin R. Evers
Executive Director
American Oversight
foia@americanoversight.org

Dear Mr. Evers:

This is the Fourth Initial Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated July 11, 2019, referred to this FOIA office on July 2, 2019, and assigned FOIA tracking number **19-09094-F.** You requested, as you phrase it:
"All emails sent or received by former Secretary David Shulkin or former Chief of Staff and Acting Secretary Peter O'Rourke on any personal, non-governmental, or nonofficial email account regarding official agency business.
[. . .]
Please provide all responsive records from November 9, 2016, through March 28, 2018."

Fourth Partial IAD & Reasonable Searches Dated 8/2/19
On August 2, 2019, OSVA received approximately twenty-two thousand (22,000) pages of emails from David Shulkin working on VA business on his aol.com and gmail.com email addresses. OSVA now releases to you one thousand nine hundred fifty-four (1,954) pages, Bates-numbered 1659-3638.

OSVA releases partial email addresses of Laurie Perlmutter (lperl), Marc Sherman (mbs), Bruce Moskowitz (brucem), whereas redacting their email addresses would not identify them as the recipients or senders. OSVA releases the names of Marc Sherman's associates Michael Zinner, Terry Fadem, and Clifford Ko, as well as Perlmutter associate Marisol Garcia. OSVA releases names of RFP panelists Amy Cooper, Stan Huff, Stephanie Reel, Jon Manis, Karson, Ed Marx, Frank Opelka, Aneesh Chopra, Cris Ross, Carla Smith, Ryan Howells, Paul Sutton, and Kenneth Mandi. VA elects to release the names and VA contact information of VA Senior Executives. VA also releases photographs of the VA Secretary, as well as public photographs.

After reviewing the one thousand nine hundred fifty-four (1,954) pages, Bates-numbered 1659-3638, OSVA redacts some information with FOIA Exemptions 4, 5, and 6. 5 U.S.C. § 552(b)(4) exempts from disclosure "trade secrets and commercial or financial information obtained from a person and privileged or confidential." "Where commercial or financial information is both customarily and actually treated as private by its owner and provided to the government under an assurance of privacy, the information is "confidential" within Exemption 4's meaning." Food Marketing Inst. v. Argus Media, No. 18-481, at *2 (U.S. June 24, 2019). Redacted information includes details of a contractor deliverable for the government, proposals, proposed technical approaches, proposed solutions, teaming or partnership agreements, and assessment methodology. Contractors typically treat such as commercially private information or having received an assurance of privacy from the VA.

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Exemption 5 protects interagency or intra-agency memorandums or letters that would not be available by law to a party other than an agency in litigation with the agency. For information on five (5) pages, VA redacts communications between the VA and the President's advisers. The presidential communications privilege protects agency communications to or from the President or his advisers. Loving v. DOD, 550 F.3d 32, 37-38 (D.C. Cir. 2008) (Exemption 5 "incorporates" Presidential Communications Privilege, which protects "'communications directly involving and documents actually viewed by the President,' as well as documents 'solicited and received' by the President or his 'immediate White House advisers'" (internal citations omitted)); Berman v. CIA, 378 F. Supp. 2d 1209, 1219-20 (E.D. Cal. 2005) (same), aff'd on other grounds, 501 F.3d 1136 (9th Cir. 2007); Judicial Watch, Inc. v. DOJ, 365 F.3d 1108, 1110 n.1 (D.C. Cir. 2004) ("embrac[ing] the definitional analysis set forth" in In re Sealed Case, 121 F.3d 729, 749-50, 752 (D.C. Cir. 1997), protecting documents covered by Presidential Communications Privilege); Amnesty Int'l USA v. CIA, 728 F. Supp. 2d 479, 522 (S.D.N.Y. 2010) ("all twenty documents reflect or memorialize communications between senior presidential advisers and other United States government officials and are therefore properly withheld"). Out of the four thousand one hundred fifty-two (4,152) pages released to you, OSVA redacted information per the presidential communications privilege on only twenty-one (21) pages.

FOIA Exemption 5 also permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts internal government deliberations, thoughts, opinions, recommendations, and solutions from federal employees reviewing in their professional capacities: VA programs, potential responses to news or Congressional inquiries, talking points, a proposed Executive Order, and unsubstantiated allegations. The information contained in the responsive records is both predecisional and deliberative because it reflects preliminary opinions, proposed solutions, recommendations, potential responses to news or Congressional inquiries, talking points, a proposed Executive Order, and unsubstantiated allegations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, proposing changes to, and making recommendations on: VA programs, potential responses to news inquiries, talking points, a proposed Executive Order, or unsubstantiated allegations. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926 F.2d 1192, 1196-97 (D.C. Cir. 1991) ("talking points" memoranda are predecisional); ACLU v. DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) ("'talking points' are predecisional . . . the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department"); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) ("The undisputed evidence establishes that these [talking points] are deliberative."); Judicial Watch, Inc. v. U.S. Dep't of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting "talking points" and recommendations on how to answer

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questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (protecting e-mail communications, "press releases, talking points and 'Q & A,'" drafts, and briefing materials); Citizens for Responsibility & Ethics in Wash. v. DHS, 514 F. Supp. 2d 36, 44 (D.D.C. 2007) (protecting briefing materials concerning Hurricane Katrina response including proposed "solutions and approaches"); Judicial Watch, Inc. v. DOE, 310 F. Supp. 2d 271, 317 (D.D.C. 2004) (protecting briefing materials for Secretary of the Interior), aff'd in part, rev'd in part on other grounds & remanded, 412 F.3d 125, 133 (D.C. Cir. 2005); Klunzinger v. IRS, 27 F. Supp. 2d 1015, 1026 (W.D. 1998) (protecting paper to brief commissioner for meeting); Thompson v. Dep't of the Navy, No. 95-347, 1997 WL 527344, at *4 (D.D.C. Aug. 18, 1997) (protecting materials to brief senior officials responding to media inquiries, as "disclosure of materials reflecting the process by which the Navy formulates its policy concerning statements to and interactions with the press" could stifle frank communication within the agency), aff'd, No. 97-5292, 1998 WL 202253, at *1 (D.C. Cir. Mar. 11, 1998) (per curiam); Williams v. DOJ, 556 F. Supp. 63, 65 (D.D.C. 1982) (protecting "briefing papers prepared for the Attorney General prior to an appearance before a congressional committee").

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, photographs, email addresses, phone numbers, cellular numbers, facsimile numbers, resume details, medical details, and photographs of: federal employees, federal contractors, veterans, private citizens, and their family members. Federal employees, federal contractors, veterans, private citizens, and their family members retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal employees, federal contractors, veterans, private citizens, and their family members whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, we find that there is no public interest in knowing the names, identities, email addresses, phone numbers, cellular numbers, facsimile numbers, resume details, medical details, and photographs of: federal employees, federal contractors, veterans, private citizens, and their family members. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the FOIA requester is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

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Out of the twenty-two thousand (22,000) pages received, OSVA has now reviewed about ten thousand two hundred (10,200) pages, of which OSVA has released four thousand one hundred fifty-two (4,152) redacted pages. About six thousand (6,000) pages predate November 9, 2019 and, thus, are non-responsive to your FOIA request. Of the released four thousand one hundred fifty-two (4,152) pages, one thousand five hundred thirty-eight (1,538) relate to the three (3) informal advisors.

On or about January 14, 2020, OSVA released seven hundred six (706) pages to you, redacted with FOIA Exemptions 5 and 6. On January 6, 2020, OSVA released to you five hundred forty-three (543) pages, non-consecutively Bates-numbered 10033-11500, redacted with FOIA Exemptions 5 and 6. The other four thousand two hundred seventy-nine (4,279) pages, within pages Bates-numbered 10033-14999, predated November 9, 2016 and, thus, are non-responsive to your FOIA request. On January 6, 2020, OSVA also re-released to you nine hundred forty-nine (949) pages, Bates-numbered 1-949, released to you on November 21, 2019, but with fewer redactions.

Approximate 25,000 Pages of Emails Received on or About 1/15/2020

On or about January 15, 2020, Mr. Shulkin submitted approximately twenty-five (25,000) thousand pages of emails in which he copied another VA employee. For your past FOIA request **18-07426-F**, OSVA has released to you all of Shulkin's aol and gmail emails, possibly redacted, in which Shulkin directly communicated with the three (3) informal advisors and copied another OSVA Senior Executive. For your FOIA request **18-11960-F**, OSVA has produced and will continue to produce all of Shulkin's aol and gmail emails referencing the three (3) informal advisors and copying another OSVA Senior Executive.

Those twenty-five thousand (25,000) pages, with Shulkin copying another VA employee, are compliant with the Federal Records Act. Those emails entered VA Systems of Records and servers at time of transmission and are agency records, not personal emails. As such, those twenty-five thousand (25,000) pages are non-responsive to your FOIA request.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:
Name: Doloras Johnson
Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)
Email Address: ogis@nara.gov
Fax: 202-741-5769
Mailing address:
National Archives and Records Administration
8601 Adelphi Road
College Park, MD 20740-6001

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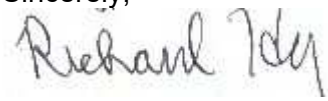
FOIA Appeal

This concludes OSVA's Fourth Partial IAD to request **19-09094-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,



Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachments – Redacted one thousand nine hundred fifty-four (1,954) pages

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Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/25/2017 1:42:25 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Fwd: VA question

I wanted to confirm with you that the two statements from the speechwriter is correct.

Darin
---------- Forwarded message ----------
From: (b) (6) **EOP/WHO** <(b) (6) who.eop.gov>
Date: Mon, Apr 24, 2017 at 6:37 PM
Subject: RE: VA question
To: Darin Selnick <(b) (6) @gmail.com>, "(b) (6) EOP/WHO"
<(b) (6) who.eop.gov>
Cc: Darin Selnick <darin.selnick@va.gov>

Thanks. Are the following statements (b) (5)

[redacted]

[redacted]

From: Darin Selnick [mailto:(b) (6) @gmail.com]
Sent: Monday, April 24, 2017 9:31 PM
To: (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Cc: (b) (6) EOP/WHO <(b) (6) who.eop.gov>; Darin Selnick <darin.selnick@va.gov>
Subject: Re: VA question

Hi (b)

(b) (5)
[redacted].

Darin

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On Mon, Apr 24, 2017 at 6:12 PM, (b) (6) EOP/WHO <(b) (6) who.eop.gov> wrote:

Hi Darin can you answer this question from (b) (5)
Thanks

> On Apr 24, 2017, at 9:06 PM, (b) (6) EOP/WHO <(b) (6) who.eop.gov> wrote:
>
> (b) (5)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/25/2017 2:27:18 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Meeting

Who is best to present the inventory system we use?

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** April 24, 2017 at 6:57:56 PM EDT
> **To:** Poonam Alaigh <(b) (6) hotmail.com>
> **Cc:** David shulkin <drshulkin@aol.com>
> **Subject: Re: Meeting**
>
> We will make it another time.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> > On Apr 24, 2017, at 6:56 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
> >
> > Bruce - good idea but we are having an offsite strategy retreat with the field and medical center leadership to engage them and galvanize them around performance, accountability and David/Presidents priorities that day - I will leave the meeting to make it just in time for the Presidents visit. Let's plan time right after the event if we can make it work
> >
> > Sent from my iPhone
> >
> > > On Apr 24, 2017, at 11:03 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
> > >
> > > Prior to signing If it helps to have a breakfast meeting to discuss inventory initiative in detail let me know. Also how we prevent over utilization in private sector. Any other issues up to you
> > >
> > > Sent from my iPad
> > > Bruce Moskowitz M.D.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/24/2017 10:57:56 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: David shulkin [drshulkin@aol.com]
Subject: Re: Meeting

We will make it another time.

Sent from my iPad
Bruce Moskowitz M.D.

> On Apr 24, 2017, at 6:56 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Bruce - good idea but we are having an offsite strategy retreat with the field and medical center leadership to engage them and galvanize them around performance, accountability and David/Presidents priorities that day - I will leave the meeting to make it just in time for the Presidents visit. Let's plan time right after the event if we can make it work
>
> Sent from my iPhone
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>> On Apr 24, 2017, at 11:03 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
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>> Prior to signing If it helps to have a breakfast meeting to discuss inventory initiative in detail let me know. Also how we prevent over utilization in private sector. Any other issues up to you
>>
>> Sent from my iPad
>> Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 6:13:10 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Marc Sherman [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]; (b) (6) (b) (6) [(b) (6) mayo.edu]
Subject: Press is covering us better

http://www.bradenton.com/opinion/editorials/article145999214.html

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/23/2017 4:59:44 PM
To: (b) (6) [(b) (6) va.gov]
CC: (b) (6) [(b) (6) va.gov]
Subject: Re: [EXTERNAL] Re: Hepatitis paper -Final version for submission

Ok thanks

(b) (6) please print

Sent from my iPhone

On Apr 23, 2017, at 11:31 AM, (b) (6) (b) (6) va.gov> wrote:

> Attached is the cover letter – with your signature Dr. Shulkin. (Please make sure I have your contact information correct, and feel free to edit if you see fit).
> Once you approve, I will plan to submit directly to the journal.
>
> (b)

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Friday, April 21, 2017 3:27 AM
To: (b) (6)
Cc: Poonam Alaigh; (b) (6)
Subject: [EXTERNAL] Re: Hepatitis paper -Final version for submission

Looks great- congratulations

I do not need to be the corresponding author but the cover should come from me as i am known to the Editors- i had an article there this week

Thanks again

Sent from my iPhone

On Apr 21, 2017, at 1:47 AM, (b) (6) (b) (6) va.gov> wrote:

> Hi,
> I am attaching the final version of the Hepatitis C paper for your approval before submitting for publication. As mentioned, I would suggest we try and submit to Annals of Internal Medicine given that they have recently published the piece on the National Strategy for hepatitis Elimination. We can submit under their "Medicine and Public Issues" section (Articles related to the economic, ethical, sociological, or political environment in medicine [Peer reviewed]).
> http://annals.org/aim/pages/authors. If it comes back then we can submit to a clinical hepatology journal.

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I have it set up to the Annals of Internal Medicine specifications (2500 words) and have added the abstract. Also added figure descriptions.

Please double check the title page to make sure I have the affiliations and disclosures correct.

Dr. Shulkin, would you like to be the corresponding author? Also, I can create a cover letter, but would you like the cover letter to have your signature on it?
Just let me know either way, what you prefer.

There are two versions – one clean copy and one with the tracked changes so you can see the final edits. These edits were made to bring it down to meet the required word count. Because there are no author limits, we have added Dr. (b) (6) as an author given his role as Director of the HCV program and his spearheading of these initiatives.

Thank you for your support!
(b)

(b) (6) *PharmD, BCPS, AAHIVP*
National Public Health Clinical Pharmacy Specialist
Patient Care Services/Population Health (10P4V)
Department of Veterans Affairs
Phone: 310-922-(b) 310-478-(b) (6)
Email: (b) (6) va.gov

From: Poonam Alaigh [mailto:(b) (6) hotmail.com]
Sent: Tuesday, April 18, 2017 4:24 AM
To: David shulkin
Cc: (b) (6)
Subject: Re: [EXTERNAL] Hepatitis paper

I am in concurrence with Dr Shulkin- thanks

Sent from my iPhone

On Apr 18, 2017, at 7:16 AM, David shulkin <Drshulkin@aol.com> wrote:

> Thank you
>
> Sent from my iPhone
>
> On Apr 18, 2017, at 1:06 AM, (b) (6)
> <(b) (6) va.gov> wrote:
>
> > Hi Dr. Shulkin and Dr. Alaigh,

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Please find attached the data on the number of veterans we have treated and our SVR (cure) rates among those we have treated since the availability of the oral DAAs.

In the attached spreadsheet (HCV VA data sources.xls), please find three tabs:

Tab 1 shows the daily cumulative total of veterans starting on oral HCV DAAs. We started prescribing in VA in Jan 2014, though they were FDA approved in Nov 2013. This summary graph is also posted and is available at the first link listed below.
Number of veterans treated since DAA availability:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/default.aspx

Tab 2 of the spreadsheet shows the number of veterans *awaiting treatment* at periodic intervals beginning with FY14 (DAAs introduced in VA in Q2 FY14). This is data captured from the HCV Clinical Case Registry. Those in the paper reflect the end of March (Q2 FY17).
This data is also posted and is available at the link listed below:
Numbers *awaiting* treatment – this is updated quarterly.
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Viremic/viremic-fib4.aspx

Tab 3 of the spreadsheet shows the raw data that relates to the "Cascade of HCV Care" (figure 3) with a brief sentence about the methods used to calculate each "step". For more detailed methods, refer to the attached Maier et al paper. We used the same methods for the current cascade as we did in this previously published paper. Note that the cascade numbers represent all HCV patients in care *ever treated* (even with earlier non-DAA regimens before 2014) which is why the SVR percentages in the cascade graph are lower than what the SVR rates are with all oral DAA regimens (shown in link below – which represent SVR rates of only oral DAA regimens from 2014 and beyond).
SVR (cure) rates with *all oral DAA regimens* are posted here and updated every two weeks:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Antivirals%20Tests/HCV_Direct_Acting_Antivirals.aspx

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From table at above link, SVR rate calculated as SVR12/(NoSVR+SVR12) = 94.98%; Published data on SVR rates available in the attached article.

HCV testing rates are updated and posted quarterly, (those in the paper reflect the end of March, Q2 FY17) : https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvbirthcohort/hcv_cohorts_fiscal_year/default.aspx

Please let me know if you have any additional questions about the data or would like to have copies of any of the other references in the paper.

Best,
(b)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Sunday, April 16, 2017 9:59 AM
To: (b) (6) (b) (6)
(b) (6) hotmail.com
Subject: [EXTERNAL] Hepatitis paper

(b) and (b) (6) and Poonam- you did a spectacular job writing this up and its a remarkable story that has occurred at VA.
I think this is exactly the type of manuscript that is needed so others can benefit from your experience and also
that VA can be appropriately recognized for its' leadership in this area.

I surprisingly made very few edits or corrections in the paper which is a real tribute to you all.
Please take a look and make sure you agree with these few changes.

The one request I would make is to be an author on this paper I feel it is important that I review the data
that you used to put the statistics in the paper about how many veterans we treated and our success rates.
Do you have any reports or data that you could share so Dr. Alaigh and I can review before we put our names on the manuscript?

I don't know if Dr. Alaigh has had time yet to review.

The annals seems appropriate or if not a hepatology journal surely would be interested.

Thanks so much for your leadership here

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David Shulkin MD

<HCV VA data sources.xlsx>

<Maier_AJPH201512546R3_2nd_ProofCXs.pdf>

<Curing hepatitsC 4-20-17 clean.docx>

<Curing hepatitsC 4-20-17 tracked changes.docx>

<Cover Letter Curing HCV in VA.docx>

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Message

From: (b) (6) [(b) (6) va.gov]
Sent: 4/23/2017 3:31:59 PM
To: David shulkin [Drshulkin@aol.com]; Shulkin, David J., MD [David.Shulkin@va.gov]
CC: Poonam Alaigh [(b) (6) hotmail.com]; (b) (6) [(b) (6) va.gov]
Subject: RE: [EXTERNAL] Re: Hepatitis paper -Final version for submission
Attachments: Cover Letter Curing HCV in VA.docx

Attached is the cover letter – with your signature Dr. Shulkin. (Please make sure I have your contact information correct, and feel free to edit if you see fit).
Once you approve, I will plan to submit directly to the journal.

(b)

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Friday, April 21, 2017 3:27 AM
To: (b) (6)
Cc: Poonam Alaigh; (b) (6)
Subject: [EXTERNAL] Re: Hepatitis paper -Final version for submission

Looks great- congratulations

I do not need to be the corresponding author but the cover should come from me as i am known to the Editors- i had an article there this week

Thanks again

Sent from my iPhone

On Apr 21, 2017, at 1:47 AM, (b) (6) (b) (6) va.gov> wrote:

> Hi,
> I am attaching the final version of the Hepatitis C paper for your approval before submitting for publication. As mentioned, I would suggest we try and submit to Annals of Internal Medicine given that they have recently published the piece on the National Strategy for hepatitis Elimination. We can submit under their "Medicine and Public Issues" section (Articles related to the economic, ethical, sociological, or political environment in medicine [Peer reviewed]).
> http://annals.org/aim/pages/authors. If it comes back then we can submit to a clinical hepatology journal.
>
> I have it set up to the Annals of Internal Medicine specifications (2500 words) and have added the abstract. Also added figure descriptions.
>
> Please double check the title page to make sure I have the affiliations and disclosures correct.
>
> Dr. Shulkin, would you like to be the corresponding author? Also, I can create a cover letter, but would you like the cover letter to have your signature on it?
> Just let me know either way, what you prefer.

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Department of Veterans Affairs
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Email: (b) (6) va.gov

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Christine Laine, MD, MPH
Editor in Chief, Annals of Internal Medicine

RE: Manuscript submission April 24, 2017

Dear Dr. Laine,

We wish to respectfully submit the manuscript entitled "**Curing Hepatitis C Infection: Best Practices from the Department of Veterans Affairs**" for consideration for publication in *Annals of Internal Medicine* as a Medicine and Public Issues article.

This manuscript directly addresses a recently published April 4th *Annals of Internal Medicine* Ideas and Opinions article by Buckley et al, which summarized the National Academies of Sciences, Engineering, and Medicine expert committee Report on a National Strategy for the Elimination of Viral Hepatitis. With VA's advancements and progress in treating veterans with hepatitis C virus infection (HCV), and as the nation's largest provider of care to patients with HCV, VA is uniquely suited to inform this Strategy.

In the attached manuscript we have highlighted VA's successes and best practices relating to each of the 5 areas identified in the National Strategy report that can be extended to other healthcare organizations and providers delivering hepatitis C care. The work underway in VA over the past 3 years has focused on a comprehensive approach to identify and manage veterans with hepatitis C. This manuscript informs the readers of our experiences, innovations, and outcome metrics across the care continuum for this population which has led to the successful treatment of over 86,000 veterans in 3 years.

This manuscript has not been previously published nor is it being considered for publication elsewhere. I attest to the fact that all authors have had a significant intellectual contribution to this work and have read and approved the submitted manuscript.

Thank you in advance for the consideration shown to this manuscript. We would appreciate the opportunity to contribute to *Annals of Internal Medicine*.

Sincerely,

David J. Shulkin MD
Secretary of Veterans Affairs
Office of the Secretary for Health
Department of Veterans Affairs
Washington, DC
202-461-7000
David.Shulkin@va.gov

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/21/2017 10:26:31 AM
To: (b) (6) [(b) (6) va.gov]
CC: Poonam Alaigh [(b) (6) hotmail.com]; (b) (6) [(b) (6) va.gov]
Subject: Re: Hepatitis paper -Final version for submission

Looks great- congratulations

I do not need to be the corresponding author but the cover should come from me as i am known to the Editors- i had an article there this week

Thanks again

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Curing Hepatitis C Infection: Best Practices from the Department of Veterans Affairs

Pamela S. Belperio PharmD[1], Maggie Chartier PsyD MPH[2], David B. Ross MD PhD MBI[2], Poonam Alaigh, MD[3], David Shulkin MD[4]

[1] Population Health Services, Department of Veterans Affairs, Palo Alto Health Care System, Palo Alto, CA

[2]Office of Specialty Care Services, Department of Veterans Affairs, Washington DC

[3]Office of the Under Secretary for Health, Department of Veterans Affairs, Washington DC

[4]Office of the Secretary, Department of Veterans Affairs, Washington DC

Short Running Title: HCV Best Practices in VA

Financial Support and Disclosures: This work was prepared independently without financial support. Drs. Belperio, Chartier, Ross, Alaigh, and Shulkin have no financial, professional or personal disclosures to report.

Corresponding Author:
Pamela S. Belperio, Pharm D, Patient Care Services/Population Health Services, Veterans Affairs Palo Alto Health Care System, 3801 Miranda Avenue (132), Palo Alto, CA 94304
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Word Count: 2499

Keywords: Veteran, access, direct acting antiviral, cascade

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VA-19-0799-D-000023

DS_00001681

Abstract (245)

The Department of Veterans Affairs (VA) is the nation's largest care provider to patients infected with hepatitis C virus (HCV) and is uniquely suited to inform national efforts to eliminate HCV. An extensive array of delivery of services, policy guidance, outreach efforts and funding has broadened the reach and capacity of VA to deliver direct acting antiviral (DAA) HCV therapy, supported by an infrastructure to effectively implement change and informed by extensive population health data analysis. VA has treated over 86,000 HCV-infected veterans since the availability of all-oral DAAs in January 2014 with cure rates exceeding 90%; only 58,000 known veterans in VA care remain potentially eligible for treatment. Key actions advancing VA's aggressive treatment of HCV include: expanding treatment capacity with non-physician providers, video telehealth and electronic technologies; expansion of integrated care to address psychiatric and substance use co-morbidities; and electronic data tools for patient tracking and outreach. Critical to effective implementation has been building infrastructure through the creation of regional multidisciplinary HCV Innovation Teams whose systems redesign efforts have produced innovative HCV practice models addressing gaps in care while providing more efficient and effective HCV management for the populations they serve. Financing for HCV treatment and infrastructure resources coupled with reduced drug pricing has been paramount to VA's success in curing HCV. VA is well poised to share and extend best HCV practices to other healthcare organizations and providers delivering HCV care, contributing to a concerted effort to reduce the burden of HCV.

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Introduction

Since the introduction of Direct Acting Antivirals (DAAs) for hepatitis C virus (HCV), the Department of Veterans Affairs (VA) has made extensive progress in advancing HCV care and curing substantial numbers of HCV-infected veterans in VA care. As the nation's largest provider of care to patients with HCV, VA is uniquely suited to inform the recently released *National Strategy for the Elimination of Viral Hepatitis,* produced by a National Academies of Sciences, Engineering, and Medicine expert committee, which emphasizes prevention, screening, and universal treatment of HCV-- areas in which VA has become a recognized leader (1-3). The National Strategy presents specific actions to reduce the burden of HCV and outlines 5 distinct areas—*Information, Interventions, Service delivery, Financing, and Research* (1,2). VA's best practices and successes, informed by extensive population health data analysis capabilities and national guidance and policies, may be useful for other healthcare providers and organizations to reduce the burden of HCV in their populations.

VA has made a substantial commitment to prioritizing HCV care as reflected in dedicated funding for HCV treatment in VA, unrestricted access to DAAs, detailed guidance on individualizing care and the establishment of Veterans Integrated Service Network (VISN) Hepatitis C Innovation Teams (HITs) (4). This work, in collaboration with other key VA offices, is largely supported by the VA's National Viral Hepatitis Program which also develops national guidance and policy, trainings, and resources for patients and providers, easily accessible on its comprehensive website (5).

The significant resources and efforts VA and its HCV providers have dedicated to prioritizing this disease at every level of the organization are being tangibly realized. Between January 2014 and March 2017, 86,000 HCV-infected veterans in VA care have received oral DAA treatment, achieving cure rates of over 90% (6-8). Currently, only 58,000 known veterans in VA care remain potentially eligible for treatment,

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compared to over 168,000 three years ago (9,10). While elimination appears attainable, VA recognizes the reality of the HCV epidemic and population; namely, many of those in care remaining to be treated have complex substance use, mental health, and medical co-morbidities, and many are challenged by homelessness, transportation, and rurality which pose significant barriers to engagement in care and treatment. The curve of elimination for HCV in VA will include a long tail of persistence driven by system, patient and care delivery determinants (Figure 1).

Information: Population Health Management

Using national databases and analytics, VA employs population health management strategies to measure, monitor and identify trends in HCV care, gaining insight into patterns of access and tailoring care provision programs accordingly. Veterans in VA care diagnosed with HCV are followed in VA's National Hepatitis C Clinical Case Registry (CCR), developed in part to ensure veterans with chronic HCV were linked to care (11). The HCV CCR, used for both local and national population reporting, provides data on the number of patients known to be infected with HCV together with critical clinical information such as patient and disease characteristics, where care is received, receipt of DAA treatment and clinical outcomes. The VA's Central Data Warehouse, a repository of electronic medical record data, has spurred the creation of local and regional HCV dashboards which offer providers access to patient-specific data reports for real-time intervention and tracking. These sources allow for comprehensive monitoring of incidence, prevalence, and disease course to identify and address barriers and assess outcomes. National, regional and individual facility level data is posted regularly, allowing providers, teams, and leadership to assess progress and goals. This leveraging of health systems data transforms numbers into knowledge and guides providers and the VA toward more informed and effective delivery of care for each veteran.

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Essential Interventions

Diagnosis and Testing

Improved case identification: A critical first step for improving HCV care is to identify those infected. In 2012, the Centers for Disease Control and Prevention (CDC) and subsequently the United States Preventive Services Task Force developed recommendations for testing any person born between 1945-1965, a cohort determined to have the highest HCV prevalence (12,13). Prior to 2014, VA guidance recommended risk-based testing and testing of Vietnam-era veterans, a group which largely overlaps with the 1945-1965 birth cohort (3). Using information systems to track screening, VA has been able to identify and target additional populations at risk for HCV, which include: African American males, for which the prevalence is double that of Caucasians (17.7% versus 8.3%); the homeless, for which the prevalence is over three times higher when compared to non-homeless (13.4% versus 3.5%); and persons who inject drugs (14,15).

Most recently, VA has screened over 78% of the 2.5 million veterans in the 1945-1965 birth cohort, and of note, 89.6% of its homeless population (15). Using updated annual prevalence calculations, VA estimates there are only approximately 15,000 remaining veterans in VA care who would test positive for HCV if the entire at-risk population were screened.

Testing initiatives: Several initiatives undertaken within VA to increase HCV testing have significantly impacted these results. These include national electronic point-of-care clinical reminders for HCV risk assessment and testing, automated letters recommending HCV testing which dually serve as a laboratory order when presented to a VA lab, weekly primary care panel reviews identifying patients with upcoming appointments who require testing, and calling patients directly. To emphasize this as a priority, VA added

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birth cohort testing as a national performance measure in 2015 and reports quarterly screening rates by facility and region. To ensure complete testing while simultaneously providing an efficient and patient-centered approach, VA adopted CDC recommendations into policy so all patients tested for HCV with a positive antibody automatically had reflex confirmatory HCV RNA testing performed with the same laboratory sample, with over 97% compliance in 2015. As a result of these collective factors, the proportion of veterans in VA care screened for HCV have increased annually by 3% to 4% and are substantially higher than other large healthcare systems (16).

Building Infrastructure

Hepatitis Innovation Team (HIT) Collaborative: Recognizing that care is not delivered the same way in all settings, regional HITs, comprising a multidisciplinary group of 15-30 healthcare providers, administrators, information technology and system redesign specialists, have implemented Lean Process Improvement methods to maximize clinical expertise and redesign the process of HCV testing, treatment, and management to provide care in the most efficient and effective way possible for the populations they serve (17). The HIT Collaborative has enabled a clinically focused foundation to share and implement best practices across and within teams, supported by local and regional administrators. The development of the HIT infrastructure which has leveraged and supported the work of dedicated VA providers has been a critical implementation arm that has allowed VA to respond to challenges in funding variability and other access issues that have arisen since the introduction of DAAs.

Service Delivery: Improving Linkage and Access

Population health data, the HIT infrastructure, and legions of dedicated providers on the ground have been instrumental in enhancing VA's outreach and engagement. Efforts have focused on raising provider

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and staff awareness about HCV testing and treatment availability, promoting direct outreach to at-risk veterans leveraging technologies like mobile phone applications and secure messaging, as well as outreach to the veteran community more broadly through national and local social media and advertising campaigns.

Expanding Capacity

Telemedicine and electronic technologies: VA has focused on increasing specialist capacity through telemedicine and clinical video telehealth (CVT), or real-time video teleconferencing, whereby HCV clinicians provide care to patients and/or consultation to other providers at another location. Largely modeled off of the ECHO project (18), the expanded HCV VA-ECHO model includes urban and rural sites, homeless care clinics, incorporates a pharmacist-led provider program, and a mental health and substance use program to aid providers in treating HCV in patients with these co-morbidities. Leveraging electronic databases HCV teams identify potential treatment candidates, notify primary care providers through the electronic medical record and provide HCV management recommendations. Similarly, primary care providers can efficiently consult HCV specialists regarding HCV care management and treatment recommendations via inter-provider electronic consults, eliminating the need for a specialty visit.

Non-physician advanced practice providers: VA has emphasized the expansion of HCV care beyond specialty providers. A substantial portion of HCV treatment has shifted outside of liver and infectious disease specialty care clinics at larger medical centers to primary care and community clinics. Treatment is often being delivered by non-physician providers such as Clinical Pharmacy Specialists, Nurse Practitioners and Physician Assistants, who have been recognized as delivering the same quality of care and providing more timely access to HCV treatment (19,20).

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In 2016, almost one-third of VA DAA prescriptions were initiated by a network of nearly 200 Clinical Pharmacy Specialists (21). VA has also recently granted full practice authority to nurse practitioners therefore expanding the potential for further use of these providers in providing hepatitis care. Targeted use of the limited number of specialists while expanding non-physician provider roles is an important practice that can be adapted from the VA system into other healthcare systems (19).

Barriers to Care

Based on VA HCV provider data collected in 2014 and 2015, it was estimated that up to 30% of veterans awaiting treatment were not currently willing or were unable to initiate HCV treatment. Major reported reasons included active alcohol/substance use, serious mental illness, documented non-adherence to medical appointments or treatment, unstable/uncontrolled medical comorbidities, inability to contact a veteran and veterans unwillingness to start treatment. As VA continues to treat more patients, an increasing number of those remaining in the untreated pool present with these challenges and accompanying resource demands to potentially modify these patient, system, or care delivery factors. Frequent reassessment is required of healthcare systems and providers to adapt their approach and resources as the barriers in untreated HCV populations shift overtime.

Addressing substance use: Recognizing alcohol and substance use as a considerable barrier to HCV treatment, VA took aggressive steps to eliminate non-evidence based, abstinence policies for HCV treatment and provided clinical guidance on effectively assessing alcohol and substance use, matching a patient's use with the actual risk of non-adherence. VA studies have consistently shown cure rates achieved among veterans with alcohol, substance use and mental health disorders are similar to those without these conditions (7,22).

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Integrated care: Accessible mental health and addiction specialists, care coordinators, case managers and social workers are invaluable resources to address the significant impediments to HCV treatment for VA's most vulnerable populations so that a veteran's treatment candidacy may be reassessed as barriers are addressed. VA has emphasized that integrated care practice models be implemented where resources permit. For facilities with more limited resources, individual aspects of this comprehensive care can be leveraged within the facility, or region via innovative practice models as detailed above.

Financing HCV Treatment

VA has faced significant financial challenges as a result of highly priced DAAs. With strong advocacy from VA HCV providers, veterans and VA leadership, expanded special purpose funding for HCV medications was made available through Congressional appropriations (4,23). Dramatic reductions in DAA pricing made possible by the steadfast negotiations of VA Pharmacy Benefits Management leadership in early 2016, simultaneous enactment of additional appropriations and removal of restrictions based on stage of liver disease solidified VA's ability to provide consistent access to HCV treatment for all veterans. Figure 2 depicts the significant impact of funding variability on DAA uptake in VA in recent years.

To comprehensively address HCV infection VA recognized extending resources beyond purchasing medications would be required. In 2016, VA boldly allocated 5% of the HCV drug budget for each VA medical center to non-drug HCV clinical resources and infrastructure. This has allowed medical facilities to independently address local barriers and identify tangible solutions to increase treatment by dedicating resources towards the initiatives described above.

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Research to Inform

The comprehensive data sources within VA and the VA's diverse HCV population provides a broad milieu for examining scientific and clinical outcomes, cost-effectiveness, patterns of care, and the impact of specific interventions. For decades, VA HCV researchers have actively contributed to the medical literature influencing and informing patient care, implementation strategies, operations and policy. Given the large number of HCV-infected veterans treated, real-world outcomes in special populations can be assessed to a greater degree than in many other healthcare environments thus providing valuable insight for other payors and healthcare systems.

Cascade of HCV Care in VA

The impact of DAAs on HCV has been transformational, making elimination seem a tangible goal, as the National Academies of Sciences, Engineering, and Medicine report highlights. Elimination can only occur when every individual with HCV infection is identified, linked to care, treated with HCV antivirals and achieves a sustained virologic response (SVR), or cure. These steps comprise the "hepatitis C cascade of care", a series of key components describing a population health approach to HCV care and a mechanism to assess performance (10,16,24-26).

Figure 3 depicts VA's HCV care advancements in each of the cascade steps between 2014 and 2016. VA estimates that 92% of veterans with HCV who have come to the VA for care in 2016 have been diagnosed, and of those, 93% have been linked to HCV care. The most significant change in the cascade has occurred in the treatment step. Among HCV-infected veterans in VA care in 2014, 27% of those linked to HCV care had ever received HCV treatment -- including all veterans treated prior to the

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availability of DAAs. At that time, 51% of those ever treated had achieved SVR. By comparison, among HCV-infected veterans in VA care in 2016, 59% of those linked to HCV care had ever received HCV treatment, with 84% ever receiving HCV treatment achieving SVR. Overall, 84,192 HCV-infected veterans in VA care in 2016 who had ever received HCV treatment had been cured.

Summary

The widespread availability of curative oral DAA medications have made the possibility of HCV elimination seem achievable. VA is steadily approaching this goal and remains committed to diagnosing and treating all veterans with HCV who are willing and able to be treated. An extensive array of delivery of services, policy guidance, outreach efforts and funding has broadened the reach and capacity of VA to deliver treatment, supported by an infrastructure to effectively implement change. The key actions that have advanced VA's HCV elimination efforts include: expanding treatment capacity with non-physician providers; use of video telehealth and modified ECHO models to expand treatment; expansion of integrated care and improvement in addressing psychiatric, substance use and medical co-morbidities; use of electronic data tools for patient tracking and outreach; and dissemination and implementation of best practices developed through the Systems Redesign efforts of regional HITs. However, it must be underscored that financing for HCV treatment and infrastructure resources coupled with reduced drug pricing has been paramount to VA's success in curing HCV and is the lynchpin in achieving elimination for any health care system and the US nationally. Recognizing the resources necessary to realize this goal and the infrastructure and innovations that could make it possible, VA is well poised to share and extend best practices to other healthcare organizations and providers delivering HCV care.

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Acknowledgments: The authors would like to acknowledge Dr. Lisa Backus for her contributions related to the generation of data used for reporting HCV testing rates, treatment rates, and cascade of care steps.

Commented [PB1]: Unfortunately we wont be able to include this acknowledgement to veterans and providers and congress. Based on author guidelines only the following is allowed:

Acknowledge only persons who have contributed to the scientific content or provided technical support. Authors must obtain written permission from anyone they list in the Acknowledgments section, including confirmation of the nature of the contribution.

I would really like to add Lisa Backus since she generated much of the data for the cascade and uptake utilization

Commented [MC2]: Love it, if we can't include David as an author – we should include him here as well:

Suggested language... The authors would also like to acknowledge, Dr. (b) for his advocacy of HCV and vision for how VA could become a national international leader in HCV testing, care and treatment.

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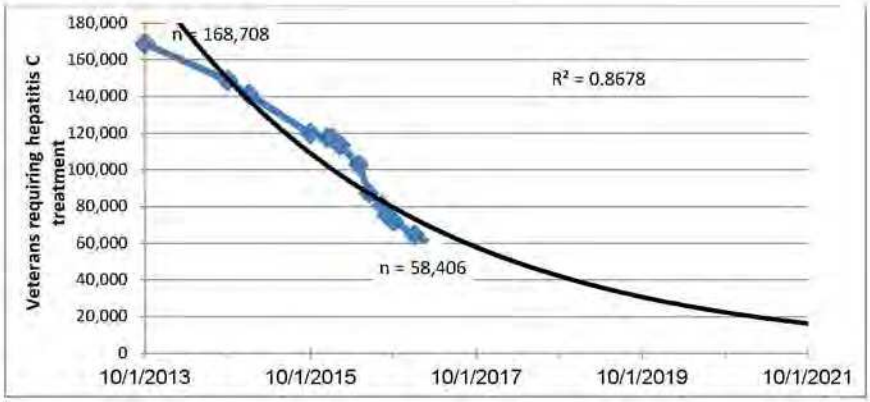

Figure 1. Number of Veterans with hepatitis C virus (HCV) in Veterans Affairs (VA) Care, requiring HCV antiviral treatment over time. In October 2013, 168,708 veterans in VA care were identified with chronic HCV and requiring treatment; by March 31, 2017, 58,406 veterans in VA care were identified as having chronic HCV and requiring treatment. R^2, coefficient of determination.

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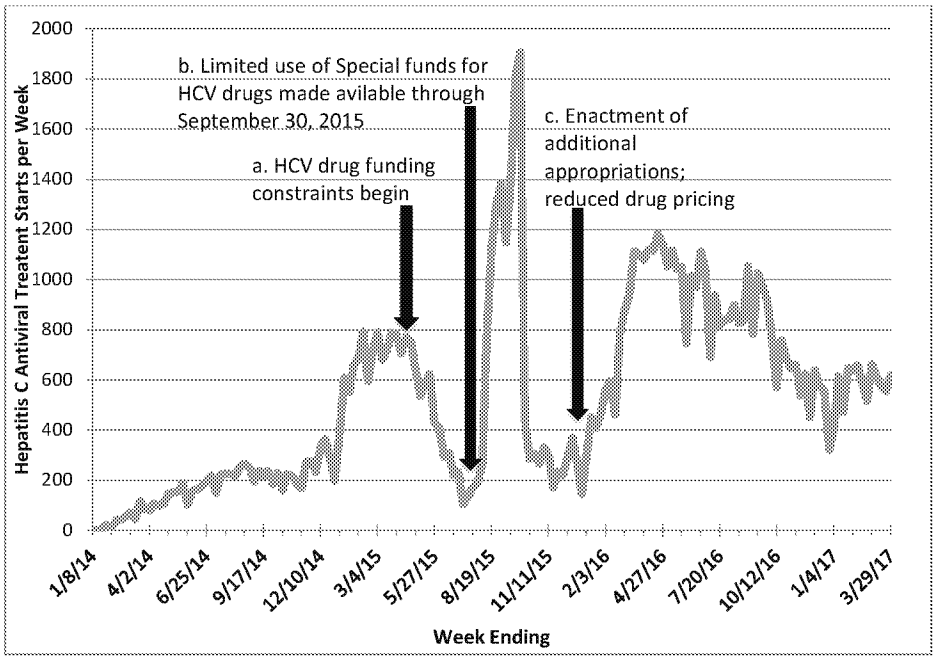

Figure 2. Impact of hepatitis C virus (HCV) drug funding availability on HCV treatment starts per week within Veterans Affairs

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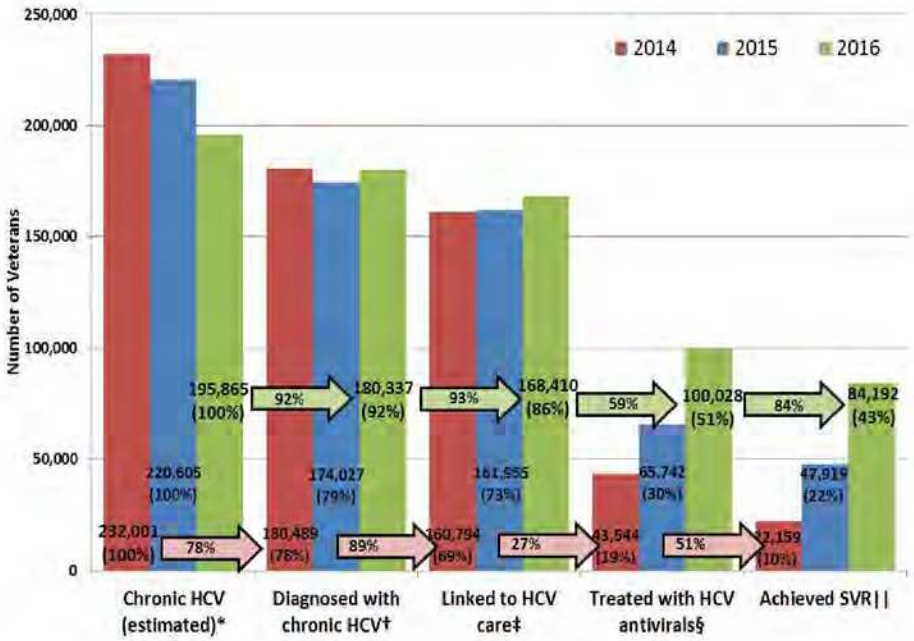

Figure 3. Cascade of HCV care in the Veterans Health Administration (VHA) in 2014, 2015, and 2016. The proportion of patients in each step of the cascade from the patients in the preceding step is presented in the arrows between each bar. SVR = sustained virologic response

*Estimated from diagnosed plus the ratio of prevalence in birth cohort strata in those tested in prior two years applied to those still untested

†Diagnosed with chronic HCV defined as ever had a detectable HCV RNA or genotype.

‡Linked to HCV care required an outpatient visit in the year, entry in the VHA's HCV registry and HCV entered on the patient's medical record problem list.

§Treated with HCV antivirals defined as ever received HCV antivirals from VHA as of 31 December of the year.

||Achieved SVR defined as undetectable HCV RNA on all tests after end of treatment including at least one test at least 12 weeks after the end of treatment

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Curing Hepatitis C Infection: Best Practices from the Department of Veterans Affairs

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Short Running Title: HCV Best Practices in VA

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Abstract (245)

The Department of Veterans Affairs (VA) is the nation's largest care provider to patients infected with hepatitis C virus (HCV) and is uniquely suited to inform national efforts to eliminate HCV. An extensive array of delivery of services, policy guidance, outreach efforts and funding has broadened the reach and capacity of VA to deliver direct acting antiviral (DAA) HCV therapy, supported by an infrastructure to effectively implement change and informed by extensive population health data analysis. VA has treated over 86,000 HCV-infected veterans since the availability of all-oral DAAs in January 2014 with cure rates exceeding 90%; only 58,000 known veterans in VA care remain potentially eligible for treatment. Key actions advancing VA's aggressive treatment of HCV include: expanding treatment capacity with non-physician providers, video telehealth and electronic technologies; expansion of integrated care to address psychiatric and substance use co-morbidities; and electronic data tools for patient tracking and outreach. Critical to effective implementation has been building infrastructure through the creation of regional multidisciplinary HCV Innovation Teams whose systems redesign efforts have produced innovative HCV practice models addressing gaps in care while providing more efficient and effective HCV management for the populations they serve. Financing for HCV treatment and infrastructure resources coupled with reduced drug pricing has been paramount to VA's success in curing HCV. VA is well poised to share and extend best HCV practices to other healthcare organizations and providers delivering HCV care, contributing to a concerted effort to reduce the burden of HCV.

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Introduction

Since the introduction of Direct Acting Antivirals (DAAs) for hepatitis C virus (HCV), the Department of Veterans Affairs (VA) has made extensive progress in advancing HCV care and curing substantial numbers of HCV-infected veterans in VA care ~~with hepatitis C virus (HCV) infection~~. As the nation's ~~single~~ largest provider of care to patients with HCV, VA is uniquely suited to inform the recently released *National Strategy for the Elimination of Viral Hepatitis,* produced by a National Academies of Sciences, Engineering, and Medicine expert committee, which emphasizes prevention, screening, and universal treatment of HCV-- areas in which VA has become a recognized leader (1-3). The National Strategy presents specific actions to reduce the burden of HCV and outlines 5 distinct areas—*Information, Interventions, Service delivery, Financing, and Research* (1,2). VA's best practices and successes, informed by extensive population health data analysis capabilities and national guidance and policies, may be useful for other healthcare providers and organizations to reduce the burden of HCV in their populations.

~~Based on US National Health and Nutrition Examination Survey data from 2010, it was estimated that approximately 13% of all patients diagnosed with HCV in the United States (US) receive care within the VA, highlighting the disproportionate burden among veterans.(3,4) In 2013, before the availability of HCV DAAs, there were approximately 168,000 veterans diagnosed with HCV infection in VA care who were potentially eligible for treatment and an additional estimated 45,000 undiagnosed in care.(5)~~

~~With support from the US House and Senate Appropriations Committees (4),~~ VA has made a substantial commitment to prioritizing HCV care as reflected in dedicated funding for HCV treatment in VA, ~~universal~~ unrestricted access to DAAs, detailed guidance on individualizing care and the establishment of Veterans Integrated Service Network (VISN) Hepatitis C Innovation Teams (HITs) (4). This work, in

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collaboration with other key VA offices, is largely supported by the VA's National Viral Hepatitis Program which also develops national guidance and policy, ~~tools,~~ trainings, and resources for patients and providers, easily accessible ~~through internal channels and~~ on its comprehensive website (5). ~~VA's success and best practices are informed by extensive population health data analysis capabilities and national guidance and policies.~~

The significant resources and efforts VA and its HCV providers have dedicated to prioritizing this disease at every level of the organization are being tangibly realized. Between January 2014 and March 2017, 86,000 HCV-infected veterans ~~enrolled~~ in VA care have received ~~potent~~ oral DAA treatment, achieving cure rates of over 90% (6-8). ~~As of March 2017~~Currently, only 58,000 known veterans in VA care ~~remain to be~~remain potentially eligible for treat~~mented~~, compared to over 168,000 three years ago (9,10). While elimination appears attainable, VA recognizes the reality of the HCV epidemic and population; namely, many of those in care remaining to be treated have complex substance use, mental health, and medical co-morbidities, and many are challenged by homelessness, transportation, and rurality which pose significant barriers to engagement in care and treatment. The curve of elimination for HCV in VA will include a long tail of persistence driven by system, patient and care delivery determinants (Figure 1).

Information: Population Health Management

Using national databases and analytics, VA employs population health management strategies to measure, monitor and identify trends in HCV care, gaining insight into patterns of access and tailoring care provision programs accordingly. Veterans in VA care diagnosed with HCV are followed in VA's National Hepatitis C Clinical Case Registry (CCR), developed in part to ensure veterans with chronic HCV were linked to care (11). The HCV CCR, used for both local and national population reporting, provides data on the number of patients known to be infected with HCV together with critical clinical

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information such as patient and disease characteristics, where care is received, receipt of DAA treatment and clinical outcomes. The VA's Central Data Warehouse, a repository of electronic medical record data, has spurred the creation of local and regional HCV dashboards which offer providers access to patient-specific data reports for real-time intervention and tracking. These sources allow for comprehensive monitoring of incidence, prevalence, and disease course to identify and address barriers and assess outcomes. National, regional and individual facility level data is posted regularly, allowing providers, teams, and leadership to assess progress and goals. This leveraging of health systems data transforms numbers into knowledge and guides providers and the VA toward more informed and effective delivery of care for each veteran.

Essential Interventions

Diagnosis and Testing

Improved case identification: A critical first step for improving HCV care is to identify those infected. In 2012, the Centers for Disease Control and Prevention and subsequently the United States Preventive Services Task Force developed recommendations for testing any person born between 1945-1965, a cohort determined to have the highest HCV prevalence (12,13). Prior to 2014, VA ~~had~~ guidance ~~in place which~~ recommended risk-based testing ~~as well as~~ and testing of Vietnam-era veterans, a group which largely overlaps with the 1945-1965 birth cohort (3). Using ~~robust~~ information systems to track screening, VA has been able to identify and target additional populations at risk for HCV, which include: African American males, for which the prevalence is double that of Caucasians (17.7% versus 8.3%); the homeless, for which the prevalence is over three times higher when compared to non-homeless (13.4% versus 3.5%); and persons who inject drugs (14,15).

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~~Since the rapid adoption of these expanded screening recommendations,~~ Most recently, VA has screened over 78% of the 2.5 million veterans in the 1945-1965 birth cohort, and of ~~particular~~ note, ~~VA has screened~~ 89.6% of its homeless population (15). Using updated annual prevalence calculations ~~from the number of new infections among those tested~~, VA estimates there are only approximately 15,000 remaining veterans in VA care who would test positive for HCV if the entire at-risk population were screened.

Testing initiatives: Several initiatives undertaken within VA to increase HCV testing have significantly impacted these results. These include national electronic point-of-care clinical reminders for HCV risk assessment and testing, automated letters recommending HCV testing which dually serve as a laboratory order when presented to a VA lab, weekly primary care panel reviews identifying patients with upcoming appointments who require testing, and calling patients directly. To emphasize this as a priority, VA added birth cohort testing as a national performance measure in 2015 and reports quarterly screening rates by facility and region. To ensure complete testing while simultaneously providing an efficient and patient-centered approach, VA ~~developed~~ adopted CDC recommendations into policy ~~in 2009 whereby so~~ all patients tested for HCV with a positive antibody automatically ~~had~~ had reflex confirmatory HCV RNA testing performed with the same laboratory sample, with over 97% compliance in 2015. As a result of these collective factors, the proportion of veterans in VA care screened for HCV have increased annually by 3% to 4% and are substantially higher than other large healthcare systems (16).

Building Infrastructure

Hepatitis Innovation Team (HIT) Collaborative: Recognizing that care is not delivered the same way in all settings, regional HITs, comprising a multidisciplinary group of 15-30 healthcare providers, administrators, information technology and system redesign specialists, have implemented Lean Process

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Improvement methods to maximize clinical expertise and redesign the process of HCV testing, ~~diagnosis,~~ treatment, and management to provide care in the most efficient and effective way possible for the populations they serve (17). The HIT Collaborative has enabled a clinically focused foundation to share and implement best practices across and within teams, supported by local and regional administrators. The development of the HIT infrastructure~~on the ground~~ which has leveraged and supported the work of dedicated VA providers, has been ~~one of the~~ a critical implementation arm that has allowed VA to respond to challenges in funding variability and other ~~critical~~ access issues that have arisen since the introduction of DAAs.

Service Delivery: Improving Linkage and Access

~~Once an enrolled veteran is diagnosed with HCV, the emphasis shifts to timely linkage to evaluation and referral for appropriate treatment. Robust p~~Population health data, the HIT infrastructure ~~of the HIT collaborative~~, and legions of dedicated providers on the ground have been instrumental in enhancing VA's outreach and engagement ~~efforts~~. Efforts have focused on raising provider and staff awareness ~~among providers and staff~~ about ~~the need for~~ HCV testing and treatment availability ~~of treatment~~, ~~as well as~~ promoting direct outreach to at-risk veterans leveraging technologies like mobile phone applications and secure messaging, as well as outreach to the veteran community more broadly through national and local social media and advertising campaigns~~, mobile phone applications, and secure messaging~~.

Expanding Capacity

Telemedicine and electronic technologies: VA has focused on increasing specialist capacity through telemedicine and clinical video telehealth (CVT), or real-time video teleconferencing, whereby HCV clinicians provide care to patients and/or consultation to other providers at another location. Largely

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modeled off of the ~~University of New Mexico~~ ECHO project (18), the expanded HCV VA-ECHO model includes urban and rural sites, homeless care clinics, incorporates a pharmacist-led provider program ~~since much of HCV treatment in VA is managed by clinical pharmacists,~~ and ~~an HCV~~ a mental health and substance use program to aid providers in treating HCV in patients with these co-morbidities. ~~Inter-provider electronic consults offer another effective and efficient way to prepare patients for treatment avoiding the need for additional appointments. Using~~ Leveraging electronic databases, ~~registries or dashboards,~~ HCV teams ~~team members can~~ identify potential treatment ~~patients who may be~~ candidates, ~~for treatment~~ notify primary care providers ~~electronically~~ through the electronic medical record ~~along with~~and provide ~~HCV recommend~~ management recommendations. Similarly, primary care providers can efficiently consult HCV specialists regarding HCV care management and treatment recommendations via inter-provider electronic consults, eliminating the need for a specialty visit.

Non-physician advanced practice providers: ~~Importantly,~~ VA has emphasized the expansion of HCV care beyond specialty providers. A substantial portion of HCV treatment ~~management~~ has shifted~~, particularly treatment,~~ outside of liver and infectious disease specialty care clinics at larger medical centers to primary care and community clinics. ~~Furthermore, this care~~Treatment is often being delivered by non-physician providers such as Clinical Pharmacy Specialists, Nurse Practitioners and Physician Assistants, who have been recognized as delivering the same quality of care and providing more timely access to HCV treatment (19,20).

In 2016, almost one-third of VA ~~all HCV antiviral~~ DAA prescriptions were initiated by a network of nearly 200 Clinical Pharmacy Specialists (21). VA has also recently granted full practice authority to nurse practitioners therefore expanding the potential for further use of these providers in providing hepatitis care. Targeted use of the limited number of specialists while expanding ~~the skills of~~ non-

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physician provider roles is ~~one of the most~~ an important practice that can be adapted from the VA system into other healthcare systems (19).

~~*Challenging Populations*~~ *Barriers to Care*

~~*Barriers to Care:*~~ Based on VA HCV provider data collected in 2014 and 2015, it was estimated that up to 30% of veterans awaiting treatment were not currently willing or were unable to initiate HCV treatment. Major reported reasons included active alcohol/substance use, serious mental illness, documented non-adherence to medical appointments or treatment, unstable/uncontrolled medical comorbidities, inability to contact a veteran and~~, in some cases,~~ veterans unwillingness to start treatment. As VA continues to treat more patients, an increasing number of those remaining in the untreated pool present with these challenges and accompanying resource demands to potentially modify these patient, system, or care delivery factors. Frequent reassessment ~~and refocusing~~ is required of healthcare systems and providers to adapt their approach and resources as the ~~needs~~ barriers in~~of its~~ untreated HCV population~~s and barriers to initiating treatment changes~~shift overtime.

Addressing substance use: Recognizing alcohol and substance use as a considerable barrier to HCV treatment, VA took aggressive steps to eliminate non-evidence based, abstinence policies for HCV treatment and provided clinical guidance on effectively assessing alcohol and substance use, matching a patient's use with the actual risk of non-adherence. VA studies have consistently shown cure rates achieved among veterans with alcohol, substance use and mental health disorders are similar to those without these conditions (7,22).

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Integrated care: Accessible mental health and addiction specialists, care coordinators, case managers and social workers are invaluable resources to address the significant impediments to HCV treatment for VA's most vulnerable populations so that a veteran's treatment candidacy may be reassessed as barriers are addressed. ~~Where resources permit,~~ VA has emphasized that integrated care~~,~~ practice models ~~care coordination, case management, and mental health and substance use services are in place~~be implemented where resources permit ~~to address factors that pose significant impediments to HCV treatment~~ for ~~vulnerable populations~~. For facilities with more limited resources, individual aspects of this comprehensive care can be leveraged within the facility, or region via innovative practice models as detailed above. ~~This comprehensive management approach facilitates care such that veterans' treatment candidacy can be reassessed. This has been particularly important for vulnerable populations. Accessible mental health and addiction specialists, care coordinators, case managers and social workers are invaluable resources to meet the individualized needs of this population.~~

Financing HCV Treatment

~~Like all healthcare systems,~~ VA has faced significant financial challenges as a result of highly priced DAAs. With strong advocacy from VA HCV providers, veterans and VA leadership, expanded special purpose funding for HCV medications was made available through Congressional appropriations (4,23). D~~The d~~ramatic reductions in ~~the price of~~ DAA pricing made possible by ~~VA~~ the steadfast negotiations of VA Pharmacy Benefits Management leadership ~~steadfast negotiations~~ in early 2016, simultaneous enactment of additional appropriations and removal of restrictions based on stage of liver disease solidified VA's ability to provide consistent access to HCV treatment for all veterans. ~~Currently, VA has no restrictions on DAAs which are available to all HCV patients regardless of stage of liver disease.~~ Figure 2 depicts the significant impact of funding variability on DAA uptake in VA ~~over~~ in recent years.

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~~Recognizing that in order t~~To comprehensively ~~and successfully treat~~ address HCV infection ~~in VA, VA~~ recognized extending resources beyond purchasing medications would be required. In 2016, VA boldly allocated 5% of the HCV drug budget for each VA medical center to non-drug HCV clinical resources and infrastructure ~~to further increase treatment starts~~. This has allowed ~~VISN HITs~~ medical facilities to independently address local barriers and identify tangible solutions to increase treatment by dedicating resources towards the initiatives described above.

~~. These funds have successfully been used to expand HCV or liver disease VA ECHO programs, increase treatment capacity through a Clinical Pharmacy Specialist initiative, increase integrated care, implement HIT innovations, host HCV testing events and fund local testing and treatment advertising campaigns.~~

Research to Inform

The comprehensive data sources within VA and the VA's diverse HCV population provides a broad milieu for examining scientific and clinical outcomes, cost-effectiveness, patterns of care, and the impact of specific interventions. For decades, VA HCV researchers have actively contributed to the medical literature influencing and informing patient care, implementation strategies, operations and policy. Given the large number of HCV-infected veterans treated, real-world outcomes in special populations can be assessed to a greater degree than in many other healthcare environments thus providing valuable insight for other payors and healthcare systems.

Cascade of HCV Care in VA

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The impact of DAAs on HCV has been ~~universally~~ transformational, making elimination seem a tangible goal, as the National Academies of Sciences, Engineering, and Medicine report highlights. Elimination can only occur when every individual with HCV infection is identified, linked to care, treated with HCV antivirals and achieves a sustained virologic response (SVR), or cure. These steps comprise the "hepatitis C cascade of care", a series of key ~~care~~ components ~~used to~~ describing a population health approach to HCV care and a mechanism to assess performance (10,16,24-26).

Figure 3 depicts VA's HCV care ~~transformation since the availability of DAAs and the impact on~~ advancements in each of the cascade steps ~~of the care cascade from~~between 2014- and 2016. ~~As of 2016,~~ VA estimates that 92% of veterans with HCV who have come to the VA for care in 2016 ~~in care have~~ have been diagnosed, and of those, 93% have been linked to HCV care. The most significant change in the cascade has occurred in the treatment step. Among HCV-infected veterans in VA care in 2014, ~~In 2014, the VA had initiated HCV treatment in~~ 27% of ~~veterans~~ those linked to HCV care had ever received HCV treatment~~VA care -- , which~~ including all veterans treated prior to the availability of DAAs. At that time, ~~with SVR in only. In turn,~~ 51% of those ever treated had achieved SVR.. By comparison, among HCV-infected veterans in VA care in 2016, ~~By the end of 2016, HCV treatment had been initiated in~~ 59% of ~~veterans~~those linked to ~~VA~~HCV care had ever received HCV treatment., with 84% ever receiving HCV treatment achieving SVR. ~~, meaning ,~~ Overall, 84,192 HCV-infected veterans ~~have been~~in VA care in 2016 who had ever received HCV treatment had been cured~~have been cured of HCV since the end of 2016, the overwhelming majority since 2014.~~

Summary

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DS_00001712

The widespread availability of curative oral DAA medications ~~that cure HCV~~ have made the possibility of HCV elimination seem achievable. VA is steadily approaching this goal and remains committed to diagnosing and treating all veterans with HCV who are willing and able to be treated. An extensive array of delivery of services, policy guidance, outreach efforts and funding has broadened the reach and capacity of VA to deliver ~~these disease-curing medications~~ treatment, supported by an infrastructure to effectively implement change. The key actions that have advanced VA's HCV elimination efforts include: expanding treatment capacity with non-physician providers; use of video telehealth and modified ECHO models to expand treatment; ~~widespread use~~expansion of integrated care and improvement in addressing psychiatric, substance use and medical co-morbidities; use of electronic data tools for patient tracking and outreach; and dissemination and implementation of best practices developed through the Systems Redesign efforts of regional HITs. However, it must be underscored that financing for HCV treatment and infrastructure resources coupled with reduced drug pricing has been paramount to VA's success in curing HCV and is the lynchpin in achieving elimination for any health care system and the US nationally. Recognizing the resources necessary to realize this goal and the infrastructure and innovations that could make it ~~truly~~ possible, VA is well poised to share and extend best ~~HCV~~ practices to other healthcare organizations and providers delivering HCV care.

Acknowledgments: ~~VA would like to thank all of the VA providers, Veterans, and Congressional appropriators who have contributed to VA's success in curing Veterans with HCV.~~ The authors would like to acknowledge Dr. Lisa Backus for her contributions related to the

Commented [PB1]: Unfortunately we wont be able to include this acknowledgement to veterans and providers and congress. Based on author guidelines only the following is allowed:

Acknowledge only persons who have contributed to the scientific content or provided technical support. Authors must obtain written permission from anyone they list in the Acknowledgments section, including confirmation of the nature of the contribution.

I would really like to add Lisa Backus since she generated much of the data for the cascade and uptake utilization

Commented [MC2]: Suggested language... The authors would also like to acknowledge, Dr. [redacted] for his advocacy of HCV and vision for how VA could become a national leader in HCV testing, care and treatment.

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VA-19-0799-D-000053

DS_00001713

generation of data used for reporting HCV testing rates, treatment rates, and cascade of care steps.

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VA-19-0799-D-000056
DS_00001716

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VA-19-0799-D-000057

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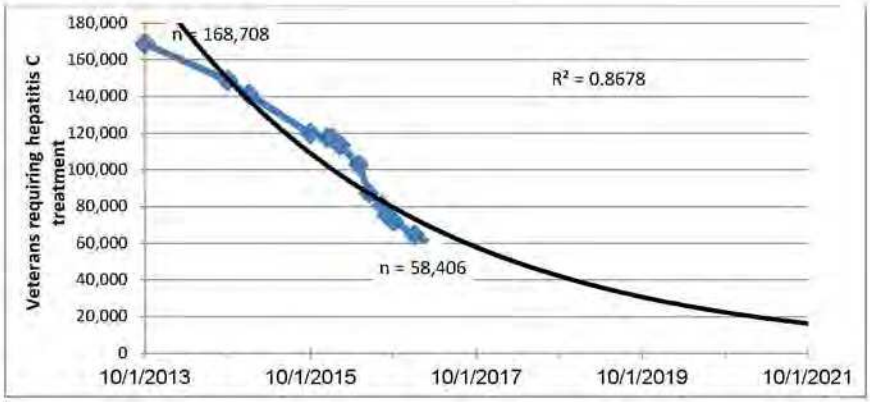

Figure 1. Number of Veterans with hepatitis C virus (HCV) in Veterans Affairs (VA) Care, requiring HCV antiviral treatment over time. In October 2013, 168,708 veterans in VA care were identified with chronic HCV and requiring treatment; by March 31, 2017, 58,406 veterans in VA care were identified as having chronic HCV and requiring treatment. R^2, coefficient of determination.

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VA-19-0799-D-000058

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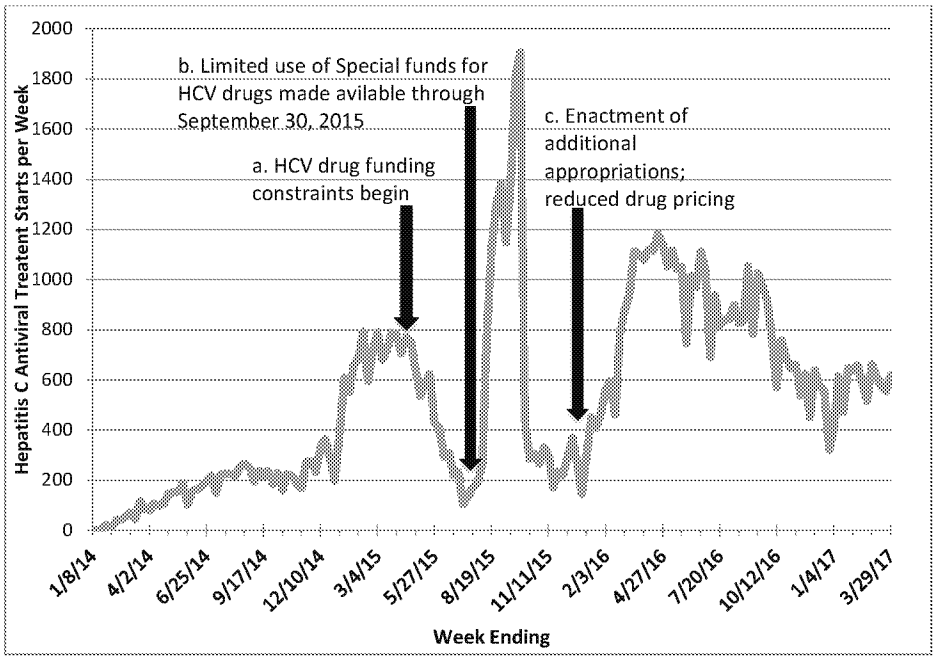

Figure 2. Impact of hepatitis C virus (HCV) drug funding availability on HCV treatment starts per week within Veterans Affairs

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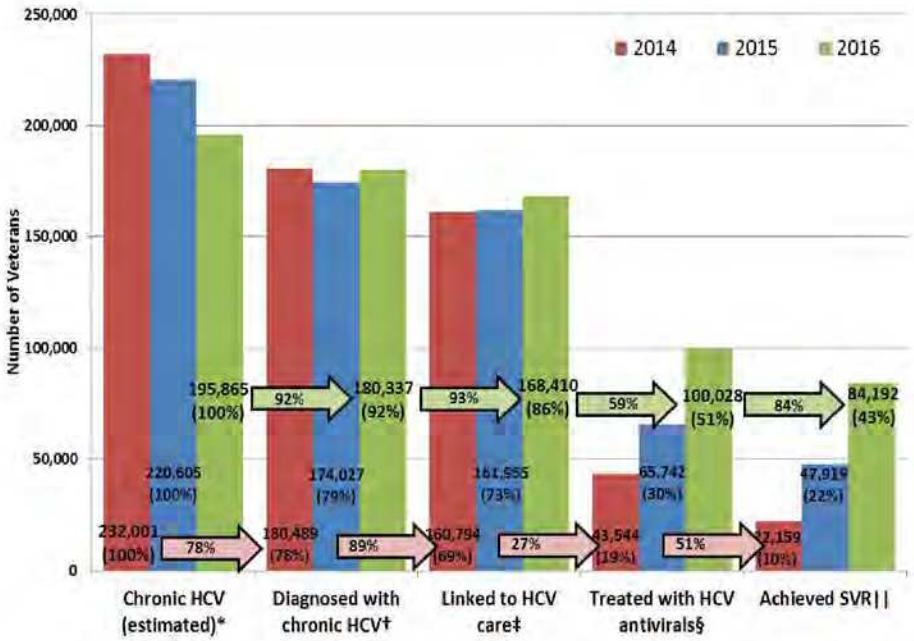

Figure 3. Cascade of HCV care in the Veterans Health Administration (VHA) in 2014, 2015, and 2016. The proportion of patients in each step of the cascade from the patients in the preceding step is presented in the arrows between each bar. SVR = sustained virologic response

*Estimated from diagnosed plus the ratio of prevalence in birth cohort strata in those tested in prior two years applied to those still untested

†Diagnosed with chronic HCV defined as ever had a detectable HCV RNA or genotype.

‡Linked to HCV care required an outpatient visit in the year, entry in the VHA's HCV registry and HCV entered on the patient's medical record problem list.

§Treated with HCV antivirals defined as ever received HCV antivirals from VHA as of 31 December of the year.

||Achieved SVR defined as undetectable HCV RNA on all tests after end of treatment including at least one test at least 12 weeks after the end of treatment

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/24/2017 9:56:02 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
BCC: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re:

Me too- i told them to stop but I think they are getting mixed messages from the WH ((b) (6) was there last week meeting with Jared) so thought it best for them to talk to you in person and hopefully we can all get on the same page

Sent from my iPhone

> On Apr 24, 2017, at 3:43 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Yes I am concerned about this
>
> Sent from my iPhone
>
>> On Apr 24, 2017, at 3:42 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Would you be interested in meeting with Darin Selnick about the Apple strategy? Im a little nervous the WH is going a different direction than you want and maybe its good for everyone to get in the same room? I wont be able to join you but i can arrange
>>
>> David
>>
>> Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/24/2017 7:54:08 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re:

Me too

Sent from my iPhone

> On Apr 24, 2017, at 3:43 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Yes I am concerned about this
>
> Sent from my iPhone
>
>> On Apr 24, 2017, at 3:42 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Would you be interested in meeting with Darin Selnick about the Apple strategy? Im a little nervous the WH is going a different direction than you want and maybe its good for everyone to get in the same room? I wont be able to join you but i can arrange
>>
>> David
>>
>> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/24/2017 7:43:27 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re:

Yes I am concerned about this

Sent from my iPhone

> On Apr 24, 2017, at 3:42 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Would you be interested in meeting with Darin Selnick about the Apple strategy? Im a little nervous the WH is going a different direction than you want and maybe its good for everyone to get in the same room? I wont be able to join you but i can arrange
>
> David
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/24/2017 7:42:22 PM
To: Bruce Moskowitz [(b) (6) mac.com]; Ike Perlmutter [(b) (6) frenchangel59.com]

Would you be interested in meeting with Darin Selnick about the Apple strategy? Im a little nervous the WH is going a different direction than you want and maybe its good for everyone to get in the same room? I wont be able to join you but i can arrange

David

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/24/2017 8:00:27 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]

Roe accepted dinner

Issakson is trying but due to health no confirmation yet

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/24/2017 7:16:07 PM
To: IP [(b) (6)frenchangel59.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; (b) (6) frenchangel59.com
Subject: Re: Dinner Attendees

Ive extended the invites- waiting to hear

Working on the DoD nsme

Email is vacodjs1@va.gov

Sent from my iPhone

On Apr 24, 2017, at 1:07 PM, IP <(b) (6) frenchangel59.com> wrote:

> Poonam and David:
>
> We need to know the information below:
>
> 1. <!--[if !supportLists]--><!--[endif]-->Please let us know if you invited Senator Isakson and Representative Roe to the dinner and if they accepted.
> 2. <!--[if !supportLists]--><!--[endif]-->Please let us know the name of the gentleman in the DOD that you would like the White House to invite.
> 3. <!--[if !supportLists]--><!--[endif]-->David, please let Marisol know your business email address so she can share with Johnson and Johnson
>
> Thank you,
> Ike

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/24/2017 5:07:54 PM
To: Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
CC: (b) (6) frenchangel59.com
Subject: Dinner Attendees

Poonam and David:

We need to know the information below:

1. Please let us know if you invited Senator Isakson and Representative Roe to the dinner and if they accepted.
2. Please let us know the name of the gentleman in the DOD that you would like the White House to invite.
3. David, please let Marisol know your business email address so she can share with Johnson and Johnson

Thank you,
Ike

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/25/2017 1:47:59 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: Non-addictive pain meds

Print

Sent from my iPad

Begin forwarded message:

From: "(b) (6) (NIH/OD) [E]" <(b) (6) od.nih.gov>
Date: April 24, 2017 at 8:58:19 PM EDT
To: "drshulkin@aol.com" <drshulkin@aol.com>
Cc: "(b) (6) (NIH/NIDA) [E]" <(b) (6) nida.nih.gov>, (b) (6) <(b) (6) speakergingrich.com>
Subject: Non-addictive pain meds

Hi David,

Newt shared with me your ideas about having the VA join the effort to deploy non-addictive pain meds. NIH is organizing a series of three workshops with industry and FDA in the next three months to make a plan. Can you recommend one or two VA experts in pain management who might be interested and available to attend?

Best, F(b)

From: (b) (6) [mailto:(b) (6) @speakergingrich.com]
Sent: Monday, April 24, 2017 1:17 PM
To: (b) (6) (NIH/OD) [E] <(b) (6) od.nih.gov>; Jared Kushner <(b) (6) WHO.EOP.GOV>
Subject: Shulkin eager to collaborate on non addictive pain effort see below newt

Sent from my iPad

Begin forwarded message:

From: David shulkin <Drshulkin@aol.com>
Date: April 19, 2017 at 7:24:18 PM EDT
To: (b) (6) <(b) (6) speakergingrich.com>
Subject: Re: Ending the Opioid Crisis fyi newt

Newt- this is very effective and well stated.

Pain is such a big issue in VA- what about making VA a fast tract FDA site to get help to veterans faster? We dont want to be experimenting on veterans but why not let veterans have the choice to receive these breakthroughs first?

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Also VA researchers could join your list of those than can help speed further discoveries.

Great job- keep it up!

David

Sent from my iPhone

On Apr 19, 2017, at 4:52 PM, (b) (6) <(b) (6) speakergingrich.com> wrote:

<Ending the Opioid Crisis.docx>

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/25/2017 1:33:55 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Non-addictive pain meds

Can you get me names? (b) (6)

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) (NIH/OD) [E]" <(b) (6) od.nih.gov>
Date: April 24, 2017 at 8:58:19 PM EDT
To: "drshulkin@aol.com" <drshulkin@aol.com>
Cc: "(b) (6) (NIH/NIDA) [E]" <(b) (6) nida.nih.gov>, (b) (6)
<(b) (6) speakergingrich.com>
Subject: Non-addictive pain meds

Hi David,

Newt shared with me your ideas about having the VA join the effort to deploy non-addictive pain meds. NIH is organizing a series of three workshops with industry and FDA in the next three months to make a plan. Can you recommend one or two VA experts in pain management who might be interested and available to attend?

Best, F(b)

From: (b) (6) [mailto:(b) (6) speakergingrich.com]
Sent: Monday, April 24, 2017 1:17 PM
To: (b) (6) (NIH/OD) [E] <(b) (6) od.nih.gov>; Jared Kushner
<(b) (6) WHO.EOP.GOV>
Subject: Shulkin eager to collaborate on non addictive pain effort see below newt

Sent from my iPad

Begin forwarded message:

From: David shulkin <Drshulkin@aol.com>
Date: April 19, 2017 at 7:24:18 PM EDT
To: (b) (6) <(b) (6) speakergingrich.com>
Subject: Re: Ending the Opioid Crisis fyi newt

Newt- this is very effective and well stated.

Pain is such a big issue in VA- what about making VA a fast tract FDA site to get help to veterans faster? We dont want to be experimenting on veterans but why not let veterans have the choice to receive these breakthroughs first?

AMERICAN OVERSIGHT

Also VA researchers could join your list of those than can help speed further discoveries.

Great job- keep it up!

David

Sent from my iPhone

On Apr 19, 2017, at 4:52 PM, (b) (6) <(b) (6) speakergingrich.com> wrote:

<Ending the Opioid Crisis.docx>

Sent from my iPad

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Message

From: Blackburn, Scott R. [Scott.Blackburn@va.gov]
Sent: 4/26/2017 2:22:20 AM
To: David Shulkin [drshulkin@aol.com]
CC: (b) (6) [(b) (6) gmail.com]; Wright, Vivieca (Simpson) [Vivieca.Wright@va.gov]
Subject: RE: [EXTERNAL] Fwd: MyVA Advisory Committee

This is great. This shouldn't be a problem.

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Tuesday, April 25, 2017 10:17 PM
To: Blackburn, Scott R.
Cc: (b) (6) Wright, Vivieca (Simpson)
Subject: [EXTERNAL] Fwd: MyVA Advisory Committee

I said yes

Sent from my iPad

Begin forwarded message:

> **From:** "(b) (6) [JJCUS]" <(b) (6) its.jnj.com>
> **Date:** April 25, 2017 at 3:59:42 PM EDT
> **To:** "'Drshulkin@aol.com'" <Drshulkin@aol.com>
> **Subject: MyVA Advisory Committee**
>
> Dear Secretary Shulkin,
>
> Thank you for your warm invitation to serve on the MyVA Advisory Committee. It is a true honor to be considered for such a role—one that helps rebuild trust with veterans and other stakeholders, improve service delivery focusing on veteran outcomes and set the course for longer-term excellence and reform.
>
> As a veteran, I share your strong commitment to improving the lives of all veterans through a healthy and well-functioning VA system. I am also pleased with your focus on reconstituting the MVAC to develop a comprehensive approach toward these goals, by sharing innovative approaches and ideas from many different areas across government, academia, and the private sector. Sharing best practices through the MVAC will help significantly advance your objectives of improving and building a world-class VA system.
>
> While I would be honored to serve on the MVAC, given the other commitments I have on my calendar, I am concerned about being able to commit the time to attend every meeting throughout the year. Although I would certainly be able to arrange my schedule to participate in several of the meetings, I would ask if it would be possible to also designate one of Johnson & Johnson's senior leaders to serve as my proxy for those meetings I am unable to attend. Please let me know if this is possible.
>
> Thank you and best wishes for continued success in your role as secretary.
>
> Sincerely,

AMERICAN OVERSIGHT

(b) (6) [redacted]

[redacted]

Johnson & Johnson

Chairman and Chief Executive Officer
Tel: (732) 524-(b) [redacted]
Fax: (732) 524-(b) [redacted]
New E-mail: (b) (6) [redacted] its.jnj.com

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/26/2017 2:17:13 AM
To: Scott R. Blackburn [Scott.Blackburn@va.gov]
CC: (b) (6) [(b) (6) gmail.com]; Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Fwd: MyVA Advisory Committee

I said yes

Sent from my iPad

Begin forwarded message:

From: "(b) (6) [JJCUS]" <(b) (6) its.jnj.com>
Date: April 25, 2017 at 3:59:42 PM EDT
To: "'Drshulkin@aol.com'" <Drshulkin@aol.com>
Subject: MyVA Advisory Committee

Dear Secretary Shulkin,

Thank you for your warm invitation to serve on the MyVA Advisory Committee. It is a true honor to be considered for such a role—one that helps rebuild trust with veterans and other stakeholders, improve service delivery focusing on veteran outcomes and set the course for longer-term excellence and reform.

As a veteran, I share your strong commitment to improving the lives of all veterans through a healthy and well-functioning VA system. I am also pleased with your focus on reconstituting the MVAC to develop a comprehensive approach toward these goals, by sharing innovative approaches and ideas from many different areas across government, academia, and the private sector. Sharing best practices through the MVAC will help significantly advance your objectives of improving and building a world-class VA system.

While I would be honored to serve on the MVAC, given the other commitments I have on my calendar, I am concerned about being able to commit the time to attend every meeting throughout the year. Although I would certainly be able to arrange my schedule to participate in several of the meetings, I would ask if it would be possible to also designate one of Johnson & Johnson's senior leaders to serve as my proxy for those meetings I am unable to attend. Please let me know if this is possible.

Thank you and best wishes for continued success in your role as secretary.

Sincerely,

(b) (6)

[redacted]

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Johnson & Johnson
Chairman and Chief Executive Officer
Tel: (732) 524-(b)
Fax: (732) 524-(b)
New E-mail: (b) (6) its.jnj.com

AMERICAN OVERSIGHT

Message

From: IP [(b) (6) frenchangel59.com]
Sent: 4/23/2017 4:50:14 PM
To: Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
Subject: FW: (b) (6) | Time.com

fyi

From: (b) (6) EOP/WHO [mailto (b) (6) who.eop.gov]
Sent: Sunday, April 23, 2017 12:19 PM
To: (b) (6) EOP/WHO; IP
Cc: Kushner, Jared C. EOP/WHO; (b) (6) EOP/WHO
Subject: RE: (b) (6) | Time.com

Reaching out to NIH on the below. The institutions / leaders that Ike assembled is literally second to none.

From: (b) (6) EOP/WHO
Sent: Saturday, April 22, 2017 7:09 PM
To: IP <(b) (6) frenchangel59.com>
Cc: Kushner, Jared C. EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Subject: Re: (b) (6) | Time.com

Adding (b) (6) also

Sent from my iPhone

On Apr 22, 2017, at 6:56 PM, IP <(b) (6) frenchangel59.com> wrote:

> The following session was just brought to my attention. It would benefit your program if all of the five CEOs from the Academic Medical Centers that are helping us with the VA effort and The Health Care Reform were to participate. They are (b) (6) from The Mayo Clinic, (b) (6) from Johns Hopkins, (b) (6) from The Cleveland Clinic, (b) (6) from Kaiser (about whom I just wrote you) and (b) (6) from Partners Healthcare. Are you able to include them on the invite list?
>
> https://www.bloomberg.com/politics/articles/2017-04-21/white-house-to-meet-biotech-research-chiefs-after-cuts-proposed
>
> ---
>
> **From:** (b) (6) EOP/WHO [mailto (b) (6) who.eop.gov]
> **Sent:** Friday, April 21, 2017 6:29 PM
> **To:** IP
> **Cc:** Kushner, Jared C. EOP/WHO; (b) (6) EOP/WHO
> **Subject:** Re: (b) (6) | Time.com
>
> Thanks for sending this along.

AMERICAN OVERSIGHT

On Apr 21, 2017, at 6:24 PM, IP <(b) (6)frenchangel59.com> wrote:

Jared, (b) (6) and (b) (6)

I would like to share with you an article on (b) (6) the Chairman and CEO of Kaiser Permanente and one of the 5 Academic Medical Center CEOs who are helping us in our effort.

(b) (6) has been named by TIME magazine as one of the 100 most influential people in the world. This is a wonderful recognition of his work and his impact on the Heath Care industry. In 2016, he was named the 2nd most influential person in Health Care by Modern Healthcare.

(b) (6) is one of the top leaders in the health care industry and has also been a tremendous advisor and resource in our work with the VA. He a strong advocate on mental health issues and supporter for the expanded use of technology in medicine. He advocates that the right technology ensures clean, aggregated data from patients' health care records which is used to avoid inconsistent treatment and errors. This is a major focus of ours which prompted our discussions with (b) (6) and Apple.

Working with (b) (6) together with the others, has allowed us to make such great progress in such a short period of time.

All my Best,

Ike

---

http://time.com/collection/2017-time-100/4742745/bernard-j-tyson/

https://share.kaiserpermanente.org/article/chairman-ceo-bernard-j-tyson-kaiser-permanente-named-no-2-modern-healthcare-list-influential-health-care-leaders/

https://www.bloomberg.com/graphics/2015-how-did-i-get-here/bernard-tyson.html

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Message

From: IP [(b) (6) frenchangel59.com]
Sent: 4/22/2017 11:52:48 PM
To: Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
Subject: FW: (b) (6) | Time.com

FYI - this is for the May 8th summit.

From: (b) (6) EOP/WHO [mailto:(b) (6) who.eop.gov]
Sent: Saturday, April 22, 2017 7:09 PM
To: IP
Cc: Kushner, Jared C. EOP/WHO; Bremberg, (b) (6) P. EOP/WHO; (b) (6) EOP/WHO
Subject: Re: (b) (6) | Time.com

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Sent from my iPhone

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> https://www.bloomberg.com/politics/articles/2017-04-21/white-house-to-meet-biotech-research-chiefs-after-cuts-proposed
>
> ---
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> **From:** Bremberg, (b) (6) P. EOP/WHO [mailto:(b) (6) who.eop.gov]
> **Sent:** Friday, April 21, 2017 6:29 PM
> **To:** IP
> **Cc:** Kushner, Jared C. EOP/WHO; (b) (6) EOP/WHO
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https://www.bloomberg.com/graphics/2015-how-did-i-get-here/bernard-tyson.html

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Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/24/2017 2:22:43 PM
To: David shulkin [Drshulkin@aol.com]
CC: Bruce Moskowitz [(b) (6) mac.com]; L Perl [(b) (6) gmail.com]; Poonam Alaigh [(b) (6) hotmail.com]; IP [(b) (6) frenchangel59.com]
Subject: Re: Hopkins

Or dinner reservation is confirmed for 7pm at i Ricchi on Wednesday evening. Once we know who is attending I can send out specifics. Everyone on this email knows where to go or has me with them as a guide.

Marc Sherman
(202) 758-(b) (6)

On Apr 23, 2017 4:43 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Sounds like a great plan- with the pilot starting in baltimore

Sent from my iPhone

On Apr 23, 2017, at 11:06 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:

(b) (6) is part of the team we need to advance the plan I proposed in the document at the end of the email. He has the ability to adapt to any existing or future EMR platform so we do not lose time on critical issues. The other part is the team that has the device registry and the team from responsive health.org will be critical to have all 3 in the meeting at the Baltimore VA. At the end of the day we will have a unique product that will be of great interest to all health care systems.

Sent from my iPad
Bruce Moskowitz M.D.

Begin forwarded message:

From: (b) (6) <(b) (6) cs.jhu.edu>
Date: April 23, 2017 at 10:40:51 AM EDT
To: Bruce Moskowitz <(b) (6) mac.com>
Cc: Aaron Moskowitz <(b) (6) brefnet.org>
Subject: Re: VA

Thanks for sharing!

As promised, here is a first draft of a one-pager on accelerating data-driven advances in healthcare. This a quick synopsis of my thinking. If you think it has legs, I can also bring in more of a brain trust around it.

Look forward to your thoughts/comments.

(b) (6)

(b) (6)
Director, Malone Center for Engineering in Healthcare

AMERICAN OVERSIGHT

Mandell Bellmore Professor, Dept. of Computer Science
Assistant: [redacted] ([redacted]jhu.edu)

<FourSteps-Moscovitz-Healthcare-V1.docx>

On Apr 22, 2017, at 2:44 PM, Bruce Moskowitz <[redacted]mac.com> wrote:

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The usual is to have a management system in place that does central purchasing keeping strict control of cost and distribution. We want to go beyond this and have:

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Tract if a particular VA is using more inventory than could be explained by patient volume to prevent pilfering of supplies.

Aside from this we are looking how to tract patients who are being treated in the private sector from having unnecessary testing, surgery or medical treatment.

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 22, 2017, at 11:07 AM, Poonam Alaigh <[redacted]hotmail.com> wrote:

Sent from my iPad

AMERICAN OVERSIGHT

Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/23/2017 8:32:41 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; (b) (6) gmail.com; IP [(b) (6) frenchangel59.com]; L Perl [(b) (6) gmail.com]
Subject: Re: Hopkins

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> > **Date:** April 23, 2017 at 10:40:51 AM EDT
> > **To:** Bruce Moskowitz <(b) (6) mac.com>
> > **Cc:** Aaron Moskowitz <(b) (6) brefnet.org>
> > **Subject: Re: VA**
> >
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> >
> > (b) (6)
> >
> > (b) (6)
> > Director, Malone Center for Engineering in Healthcare
> > Mandell Bellmore Professor, Dept. of Computer Science
> > Assistant: (b) (6) ((b) (6) jhu.edu)

<FourSteps-Moscovitz-Healthcare-V1.docx>

AMERICAN OVERSIGHT

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To: David shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]
CC: mbs(b) (6) @gmail.com; IP [(b) (6) frenchangel59.com]; L Perl [(b) (6) gmail.com]
Subject: Hopkins
Attachments: FourSteps-Moscovitz-Healthcare-V1.docx; Untitled attachment 04128.htm

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(b) (6)
Director, Malone Center for Engineering in Healthcare
Mandell Bellmore Professor, Dept. of Computer Science
Assistant: (b) (6) ((b) (6) jhu.edu)

AMERICAN OVERSIGHT

A Four Step Plan to Advance High-Value Healthcare

(b) (6) [redacted]

Draft 1: 4/23/17

Today's healthcare landscape is fragmented, inconsistent, and costly. The same patient can go to two different clinics, get two different diagnoses and treatments, and pay two (sometimes startlingly) different costs. This is wrong for the patient individually, and costs the nation as a whole. Thus, the key question we seek to address is:

How can we ensure that every patient can go into any clinic or hospital and ensure that patient gets the same high quality of care for the same cost no matter where they go?

There is only one answer to this question: data describing both patient and the performance of healthcare organizations must be made accessible, sharable and actionable. We must promote a culture of openness, discovery, sharing, and action, and create an innovation system that finds value in data, and drives that value into the world. The solution must bridge the gap between existing health records systems, which are typically unique to an organization, and the power of private-sector innovation to mine, structure, and produce actionable results from data.

To make this operational, we need to spur private-sector R&D to address immediate, high-priority challenges that exist today, and expand those efforts to "get ahead of the curve" and address the challenges of tomorrow now.

Our proposal has four key points:

1) **Create very low barriers to entry to healthcare data** for both the private sector and research organizations so that more organizations can rapidly explore the opportunity space. Accelerate this by creating consistent and standardized linkages into existing EHR systems to reduce needless replication of effort.

2) **Create a standardized value return system,** together with standardized legal and privacy safeguards, for all stakeholders. More specifically, any value created by a company from the EHR that is adopted and scaled will be returned, in part, to the providers of the data. The government can help spur this development through public/private partnerships that define and create common infrastructure and convene a group to define the "rules of engagement."

3) **Create a "clearing house" of high priority problems** for the VA as a starting point, and develop 3-5 focused "loss-leader" pilot projects that can identify common barriers and which can explore the common infrastructure and policy issues necessary to address them.

4) **Define mechanisms for external companies to implement with healthcare organizations** to accelerate deployment and testing of new technologies in patient monitoring and care.

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AMERICAN OVERSIGHT

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From: David Shulkin [drshulkin@aol.com]
Sent: 4/24/2017 7:09:56 PM
To: (b) (6) [redacted]gmail.com
Subject: slides
Attachments: april25thtoppriorities.pptx

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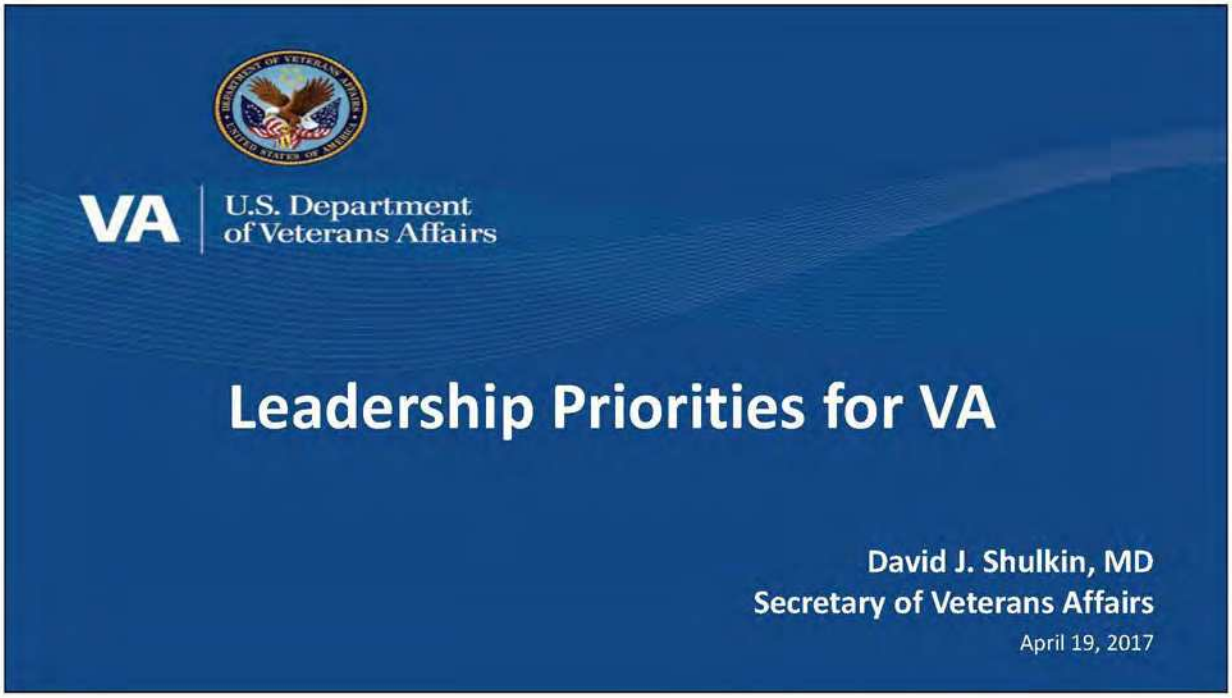

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Don't Plan on Incremental Change



VA | U.S. Department of Veterans Affairs

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The Next Phoenix?



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Ask the Right Questions

Two Things Every Leader Needs to Know:

- **Am I pushing too hard or not hard enough?**
- **What don't I know that is likely to damage the organization?**

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What Else Don't We Know? Identify the Risk

- Wait Times- 144 sites with Primary Care waits greater than 30 days
  51 sites with Mental Health waits greater than 30 days
  68 sites with Specialty care waits greater than 30 days
- Infrastructure and Equipment- 1.4 Billion in projects on hold
- Systems- Inventory Control
- Staffing- Loss of nurses in Buffalo
- What Else?

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Why Now?

What happens if we don't change?





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Making Tough Decisions (Quicker)



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United's Response



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Demonstrate Your Commitment to the Mission



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Take on the Tough Issues
Run Towards the Gun Fire





VA | U.S. Department of Veterans Affairs

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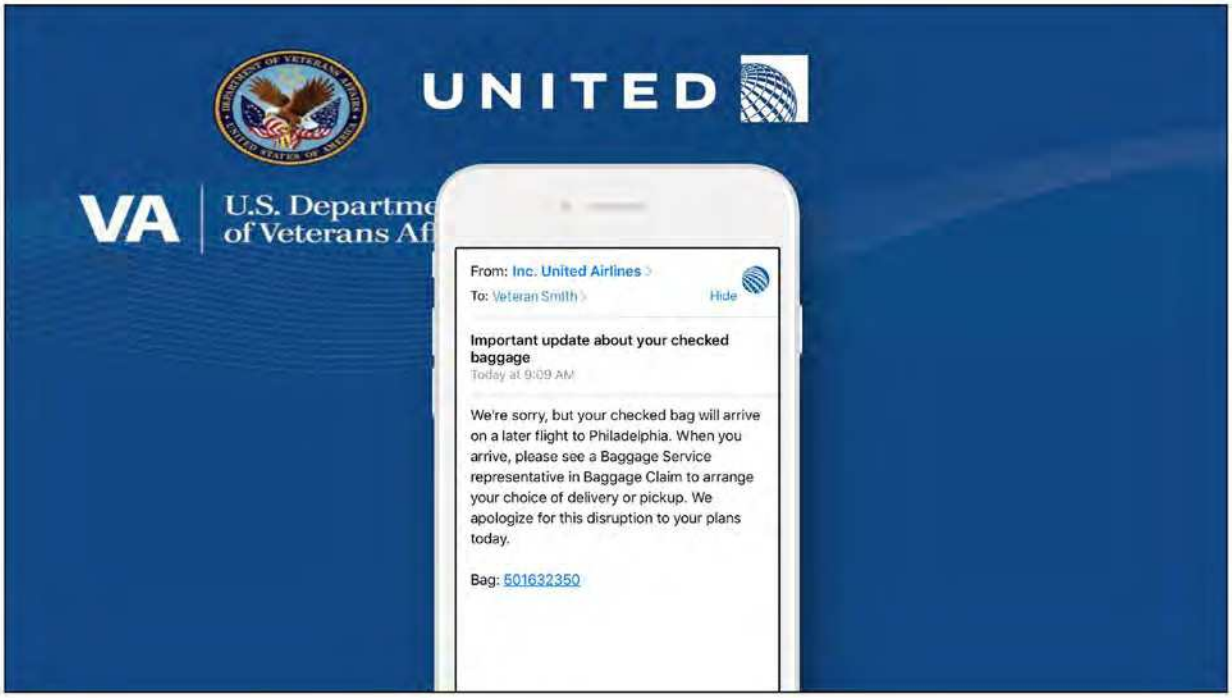

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Focus On Your People





U.S. Department of Veterans Affairs

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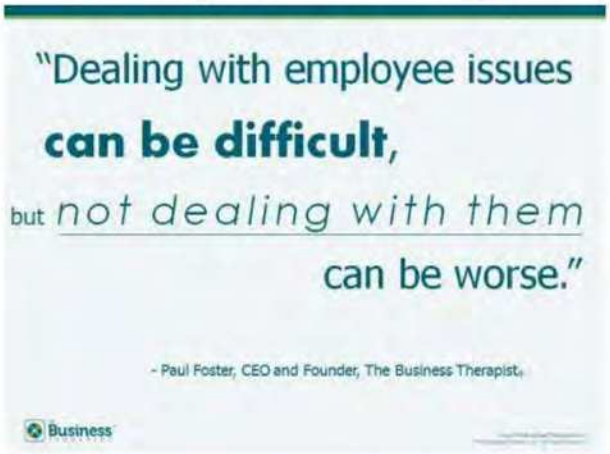
Rid Organizations of Bad Actors (Stop Detailing)



VA U.S. Department of Veterans Affairs

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First 100 Days

Choice Program Extension
Accountability Bill passes the House
Wait Time Transparency Tool Released
Public Private Partnership Announced in Omaha
Mental Health Care for Other than Honorable Discharges
Veterans Crisis Line reduces Rollover Rate from 35% to <1%
Reachvet Rollout to 6000 veterans
VBA goes paperless in 6 sites
NCA strengthens community relationships in land swap
New Family and Caregiver Taskforce

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Break

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CBS Clip on North Carolina

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My Priorities

1. Greater Choice for Veterans
2. Modernize our Systems
3. Focus Resources More Efficiently
4. Improve Timeliness of Services
5. Suicide Prevention



VA U.S. Department of Veterans Affairs

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1. Greater Choice for Veterans

- Redesign the 40/30 Rule to use clinical criteria for choice

  veteran choice
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information

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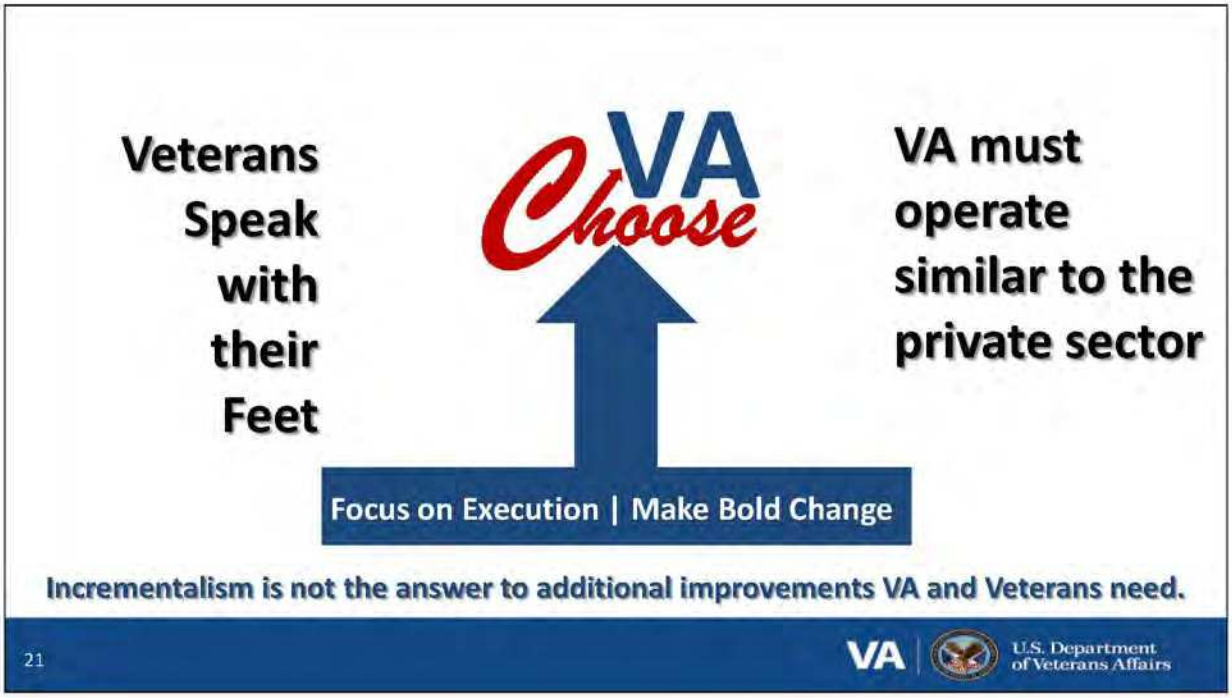

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2- Modernize Our Systems

- Infrastructure improvements and streamlining services
- EMR interoperability and IT modernization

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Infrastructure Improvements



Officers' Quarters
Fort Thomas, KY
Circa 1895



Gas Station
Minneapolis, MN
1932



Palo Alto VAMC
2017

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3. Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

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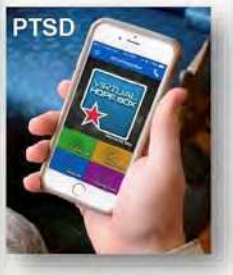
World Class Foundational Services











VA U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Accountability Legislation



Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Direct Hire for Medical Center Directors and Network Directors	Ability to fully utilize our relocation, recruitment, and retention awards	Authority to reccoop relocation expenses authorized through fraud of malfeasance.	Increased **protections for whistleblowers** .

VA | U.S. Department of Veterans Affairs

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4. Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

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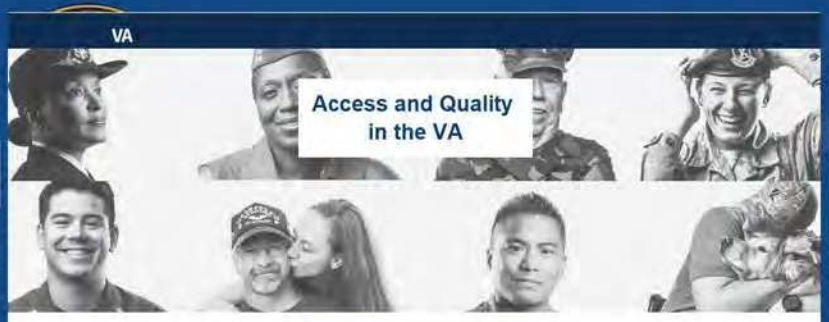
VA



How quickly does my VA see patients?

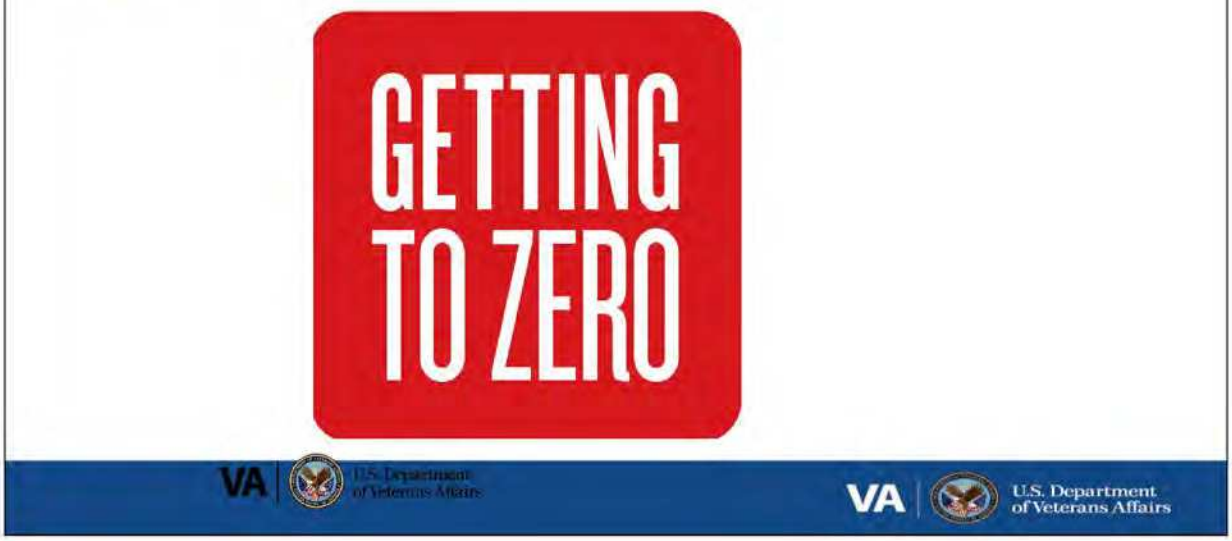
How satisfied are veterans like me with the timeliness of their care?

How well does my VA's care compare to other hospitals?

VA Pre-Decisional

AMERICAN OVERSIGHT

5- Suicide Prevention



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Suicide Prevention Coordinator Video Clip Here

AMERICAN OVERSIGHT

New Announcements This Week

Fraud, Waste and Accountability Initiatives

New VA and Public Health Service Partnership

Big Data Initiatives

Decreased Red Tape through Policy Changes across the country

VACO Modernization Decisions

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Next 100 Days

Design and Introduce New Choice Legislation

Senate Accountability Legislation

Appeals Legislation

Getting to Zero Campaign

Capital Assets Plan

EMR Decision by July

Same Day Services in CBOCs

Decision Ready Claims

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Decisions at VACO

Consolidate Mental Health into One Health

Consolidate VACO Communications

Consolidate VACO OCLA

Implement HR Shared Services

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AMERICAN OVERSIGHT

What else?

VA U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/23/2017 10:13:49 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]

http://www.generalatlantic.com/people/william-ford/

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b) (6) frenchangel59.com]
Sent: 4/24/2017 2:06:01 PM
To: David shulkin [Drshulkin@aol.com]
CC: (b) (6) va.gov
Subject: FW: David Shulkin e-mail

Hi David,

Ike would like to give Johnson and Johnson your business email address if you agree.

Is that OK with you?

Can you please give me that email address?

Thank you,

Marisol

From: (b) (6)
Sent: Monday, April 24, 2017 8:09 AM
To: 'Marisol Garcia ((b) (6) frenchangel59.com)'
Subject: David Shulkin e-mail

Hi Marisol – Hope you had a great weekend. Can you send me David Shulkin's email address – we received a letter from him and we were responding by email and the email address given in the letter was not working.

(b) (6)

[redacted]
Exec. Assistant to (b) (6) Chairman and CEO
Johnson & Johnson
One Johnson & Johnson Plaza
New Brunswick, NJ 08933
Phone: 732-524-(b) (6)
Fax: 732-524-(b)
e-mail (b) (6) @its.jnj.com

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/23/2017 1:56:42 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

It was very good David-agree, they made a headliner out of something so innocuous

---

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, April 22, 2017 11:56 AM
To: Poonam Alaigh
Subject:

This morning

http://www.cbsnews.com/videos/va-secretary-david-shulkin-on-challenges-facing-the-agency/?ftag=CNM-00-10aab4i



VA Secretary David Shulkin on challenges facing the agency

www.cbsnews.com

President Trump signed a law this week extending a pilot program on health care for veterans that allows some to receive treatment through private providers. Veterans Affairs Secretary David Shulkin joins "CBS This Morning: Saturday" to discuss the challenges facing the agency and the issues affecting veterans.

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 3:56:28 PM
To: Poonam Alaigh [(b) (6) hotmail.com]

This morning

http://www.cbsnews.com/videos/va-secretary-david-shulkin-on-challenges-facing-the-agency/?ftag=CNM-00-10aab4i

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/21/2017 10:42:20 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: What do you think

I thought your view on consultants had changed- anyway, we should discuss this on the train- if we collectively have to succeed- we need the right team - otherwise our traction will only be short lived - this has to be our #1 priority - surrounding ourselves with the right people!!

Sent from my iPhone

> On Apr 21, 2017, at 6:24 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> You of course can do what you want
>
> I think you need a strong pdush and dushom for what you need
>
> Cos needs to be string too but cannot manage your issues outside- where the crises occur
>
> Blackburn wont do it and even if he would dont see him as strong - what has he done? What is he doing? He is a consultant that talks a good game but does very little
>
> Sent from my iPhone
>
>> On Apr 21, 2017, at 6:04 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>
>> Jon Perlin and I had lunch together yesterday and one big advice he gave was regarding the criticality of the chief of staff- I don't think I have the right executive in that role - I have been thinking about it all night- suddenly it struck me that scott Blackburn could do it- what do yuh think - I trust him, he has somewhat of a strategic sense and I think because of his other roles, he will be able to implement and address things - Jon spent the entire lunch helping me understand how we needed to elevate this role from a "super secretary" to an executive that is the #2 person. I realize now that I have been drowning because I am working with supersecrtaries
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/21/2017 10:24:27 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: What do you think

You of course can do what you want

I think you need a strong pdush and dushom for what you need

Cos needs to be string too but cannot manage your issues outside- where the crises occur

Blackburn wont do it and even if he would dont see him as strong - what has he done? What is he doing? He is a consultant that talks a good game but does very little

Sent from my iPhone

> On Apr 21, 2017, at 6:04 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Jon Perlin and I had lunch together yesterday and one big advice he gave was regarding the criticality of the chief of staff- I don't think I have the right executive in that role - I have been thinking about it all night- suddenly it struck me that scott Blackburn could do it- what do yuh think - I trust him, he has somewhat of a strategic sense and I think because of his other roles, he will be able to implement and address things - Jon spent the entire lunch helping me understand how we needed to elevate this role from a "super secretary" to an executive that is the #2 person. I realize now that I have been drowning because I am working with supersecrtaries
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/21/2017 10:04:03 AM
To: David Shulkin [drshulkin@aol.com]
Subject: What do you think

Jon Perlin and I had lunch together yesterday and one big advice he gave was regarding the criticality of the chief of staff- I don't think I have the right executive in that role - I have been thinking about it all night- suddenly it struck me that scott Blackburn could do it- what do yuh think - I trust him, he has somewhat of a strategic sense and I think because of his other roles, he will be able to implement and address things - Jon spent the entire lunch helping me understand how we needed to elevate this role from a "super secretary" to an executive that is the #2 person. I realize now that I have been drowning because I am working with supersecrtaries

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 3:13:09 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Aww

No its not easy

Sent from my iPhone

On Apr 22, 2017, at 11:10 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> In addition, his wife is leading an organization that is pro- ACA- not an easy situation

---

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, April 22, 2017 8:28 AM
To: Poonam Alaigh
Subject: Fwd: Aww

http://m.ndtv.com/world-news/indian-american-surgeon-general-asked-to-step-down-by-trump-government-1684567



Trump Administration Asks Indian-American Surgeon General To Step Down

m.ndtv.com

Indian-American Surgeon General Vivek Murthy, app
by the previous Obama regime, has been asked to st
down by the Trump administration to put its own lea
in place.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/22/2017 3:10:13 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Aww

In addition, his wife is leading an organization that is pro- ACA- not an easy situation

---

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, April 22, 2017 8:28 AM
To: Poonam Alaigh
Subject: Fwd: Aww

http://m.ndtv.com/world-news/indian-american-surgeon-general-asked-to-step-down-by-trump-government-1684567



Trump Administration Asks Indian-American Surgeon General To Step Down

m.ndtv.com

Indian-American Surgeon General Vivek Murthy, appointed by the previous Obama regime, has been asked to step down by the Trump administration to put its own leadership in place.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 12:33:44 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Aww

How long is the aha presentation for?

Sent from my iPhone

On Apr 22, 2017, at 8:15 AM, (b) (6) <(b) (6) gmail.com> wrote:

> http://m.ndtv.com/world-news/indian-american-surgeon-general-asked-to-step-down-by-trump-government-1684567

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 12:28:55 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Aww

I heard this am

Sent from my iPhone

On Apr 22, 2017, at 8:15 AM, (b) (6) <(b) (6) gmail.com> wrote:

> http://m.ndtv.com/world-news/indian-american-surgeon-general-asked-to-step-down-by-trump-government-1684567

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 12:28:43 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Aww

http://m.ndtv.com/world-news/indian-american-surgeon-general-asked-to-step-down-by-trump-government-1684567

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/22/2017 12:15:47 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Aww

http://m.ndtv.com/world-news/indian-american-surgeon-general-asked-to-step-down-by-trump-government-1684567

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 10:24:53 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Today

Ok

Sent from my iPhone

> On Apr 19, 2017, at 6:06 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Would've been so sweet for me to be with you when Brian is there - want so much for that!! Next opportunity for sure!
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/19/2017 10:06:27 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Today

Would've been so sweet for me to be with you when Brian is there - want so much for that!! Next opportunity for sure!

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 6/11/2017 2:09:59 PM
To: Marisol Garcia [(b) (6) frenchangel59.com]
CC: L Perl [(b) (6) gmail.com]; (b) (6) hotmail.com; David shulkin [Drshulkin@aol.com]; mbs(b) (6) @gmail.com; (b) (6) frenchangel59.com
Subject: Re: PRE-CONFERENCE CALL TODAY SUNDAY, JUNE 11TH AT 10:30 AM -- PLEASE NOTE THAT WE HAVE A DIFFERENT CONFERECE TELEPHONE NUMBER FOR THIS CALL

Saw this will use this call in

Sent from my iPad
Bruce Moskowitz M.D.

On Jun 11, 2017, at 10:02 AM, Marisol Garcia <(b) (6) frenchangel59.com> wrote:

Good morning – Any questions please call me at 212-576-(b) (6)

Sunday, June 11th

10:30 AM – 10:50 AM EST

Dial-in Information:
US: 1-605-475-5604

Passcode: 521933#

Participants:
Laurie (Optional)
Marc Sherman – Not sure if able to participate
Secretary David Shulkin and Poonam Alaigh
Dr. Bruce Moskowitz and Ike

All my Best,
Marisol
212-576-(b) (6) (Office)
212-576-(b) (6) (Weekend)
646-668-(b) (6) (Cell)
Email: (b) (6) frenchangel59.com

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: Marisol Garcia [(b) (6) frenchangel59.com]
Sent: 6/11/2017 2:02:12 PM
To: L Perl [(b) (6) gmail.com]; (b) (6) hotmail.com; David shulkin [Drshulkin@aol.com]; Bruce Moskowitz [(b) (6) mac.com]; mbs(b) (6) @gmail.com; (b) (6) frenchangel59.com
Subject: PRE-CONFERENCE CALL TODAY SUNDAY, JUNE 11TH AT 10:30 AM -- PLEASE NOTE THAT WE HAVE A DIFFERENT CONFERECE TELEPHONE NUMBER FOR THIS CALL

Good morning – Any questions please call me at 212-576-(b) (6)

Sunday, June 11th

10:30 AM – 10:50 AM EST

Dial-in Information:
US: 1-605-475-(b) (6)

Passcode: (b) (6)

Participants:
Laurie (Optional)
Marc Sherman – Not sure if able to participate
Secretary David Shulkin and Poonam Alaigh
Dr. Bruce Moskowitz and Ike

All my Best,
Marisol
212-576-(b) (6) (Office)
212-576-(b) (6) (Weekend)
646-668-(b) (6) (Cell)
Email: (b) (6) frenchangel59.com

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/23/2017 2:39:08 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Stan

Sure

Sent from my iPhone

> On Apr 23, 2017, at 9:23 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Do you have time to join stan and I for dinner on 5/22- Monday. He called yesterday, has been going through a lot- he will be in dc that day
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/23/2017 1:23:18 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Stan

Do you have time to join stan and I for dinner on 5/22- Monday. He called yesterday, has been going through a lot- he will be in dc that day

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/26/2017 2:39:26 AM
To: (b) (6) [(b) (6) hotmail.com]
Subject: Re: [EXTERNAL] RE: two questions

645- I may get home sooner

Sent from my iPad

On Apr 25, 2017, at 10:08 PM, (b) (6) <(b) (6) hotmail.com> wrote:

> Great what time do u pick me up?
>
> Sent from my iPhone
>
> On Apr 25, 2017, at 10:04 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** "(b) (6) <(b) (6) (b) (6) va.gov>
> > **Date:** April 25, 2017 at 6:58:45 PM EDT
> > **To:** 'drshulkin' <drshulkin@aol.com>
> > **Subject: FW: [EXTERNAL] RE: two questions**
> >
> > -----Original Message-----
> > **From:** Marisol Garcia [(b) (6) frenchangel59.com]
> > **Sent:** Tuesday, April 25, 2017 06:29 PM Eastern Standard Time
> > **To:** (b) (6)
> > **Cc:** (b) (6)
> > **Subject:** RE: [EXTERNAL] RE: two questions
> >
> > Yes. We have (b) (6) as attending. Thank you
> >
> > ---
> >
> > **From:** (b) (6) [mailto(b) (6) (b) (6) va.gov]
> > **Sent:** Tuesday, April 25, 2017 12:25 PM
> > **To:** 'Marisol Garcia'
> > **Cc:** (b) (6)
> > **Subject:** RE: [EXTERNAL] RE: two questions

AMERICAN OVERSIGHT

Dr. Shulkin's wife – [redacted] Shulkin

From: Marisol Garcia [mailto:[redacted]@frenchangel59.com]
Sent: Tuesday, April 25, 2017 12:24 PM
To: [redacted]
Cc: [redacted]
Subject: [EXTERNAL] RE: two questions

I am sorry who is [redacted]

We are trying to get the names of the CEO's as soon as possible.

Thank you

From: [redacted] [mailto:[redacted]va.gov]
Sent: Tuesday, April 25, 2017 11:51 AM
To: Marisol Garcia ([redacted]@frenchangel59.com)
Cc: [redacted]
Subject: two questions

Hi Marisol,

Would it be ok for [redacted] to attend the dinner tomorrow at 7pm with Ike, Jared etc?

Do you know the names of the ceo's that want to attend with Ike on Thursday here at VA for the Potus event? The Secretary mentioned – [redacted] and [redacted]

Thanks

AMERICAN OVERSIGHT

(b) (6) MBA
Special Advisor to the Secretary

Department of Veterans Affairs

202-461-(b) (6)

202-834-(b) (6)

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]hotmail.com]
Sent: 4/26/2017 2:08:14 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] RE: two questions

Great what time do u pick me up?

Sent from my iPhone

On Apr 25, 2017, at 10:04 PM, David shulkin <Drshulkin@aol.com> wrote:

> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** "[redacted] <[redacted]va.gov>
> **Date:** April 25, 2017 at 6:58:45 PM EDT
> **To:** 'drshulkin' <drshulkin@aol.com>
> **Subject: FW: [EXTERNAL] RE: two questions**
>
> -----Original Message-----
> **From:** Marisol Garcia [[redacted]frenchangel59.com]
> **Sent:** Tuesday, April 25, 2017 06:29 PM Eastern Standard Time
> **To:** [redacted]
> **Cc:** [redacted]
> **Subject:** RE: [EXTERNAL] RE: two questions
>
> Yes. We have [redacted] as attending. Thank you
>
> ---
>
> **From:** [redacted] [mailto:[redacted]va.gov]
> **Sent:** Tuesday, April 25, 2017 12:25 PM
> **To:** 'Marisol Garcia'
> **Cc:** [redacted]
> **Subject:** RE: [EXTERNAL] RE: two questions
>
> Dr. Shulkin's wife – [redacted] Shulkin
>
> ---
>
> **From:** Marisol Garcia [mailto:[redacted]@frenchangel59.com]
> **Sent:** Tuesday, April 25, 2017 12:24 PM
> **To:** [redacted]

AMERICAN OVERSIGHT

Cc: [redacted]
Subject: [EXTERNAL] RE: two questions

I am sorry who is [redacted]

We are trying to get the names of the CEO's as soon as possible.

Thank you

From: [redacted] [mailto:[redacted]va.gov]
Sent: Tuesday, April 25, 2017 11:51 AM
To: Marisol Garcia ([redacted]g@frenchangel59.com)
Cc: [redacted]
Subject: two questions

Hi Marisol,

Would it be ok for [redacted] to attend the dinner tomorrow at 7pm with Ike, Jared etc?

Do you know the names of the ceo's that want to attend with Ike on Thursday here at VA for the Potus event? The Secretary mentioned – [redacted] and [redacted]

Thanks

[redacted] MBA
Special Advisor to the Secretary

Department of Veterans Affairs

202-461-[redacted]

202-834-[redacted]

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/26/2017 1:59:38 AM
To: (b) (6) [(b) (6) hotmail.com]
Subject: Fwd: [EXTERNAL] RE: two questions

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6) va.gov>
Date: April 25, 2017 at 6:58:45 PM EDT
To: 'drshulkin' <drshulkin@aol.com>
Subject: FW: [EXTERNAL] RE: two questions

-----Original Message-----
From: Marisol Garcia [(b) (6) frenchangel59.com]
Sent: Tuesday, April 25, 2017 06:29 PM Eastern Standard Time
To: (b) (6)
Cc: (b) (6)
Subject: RE: [EXTERNAL] RE: two questions

Yes. We have (b) (6) as attending. Thank you

From: (b) (6) [mailto(b) (6) va.gov]
Sent: Tuesday, April 25, 2017 12:25 PM
To: 'Marisol Garcia'
Cc: (b) (6)
Subject: RE: [EXTERNAL] RE: two questions

Dr. Shulkin's wife – (b) (6) Shulkin

From: Marisol Garcia [mailto(b) (6) @frenchangel59.com]
Sent: Tuesday, April 25, 2017 12:24 PM
To: (b) (6)
Cc: (b) (6)
Subject: [EXTERNAL] RE: two questions

I am sorry who is (b) (6)

AMERICAN OVERSIGHT

We are trying to get the names of the CEO's as soon as possible.

Thank you

From: [b) (6)] [mailto[b) (6)]va.gov]
Sent: Tuesday, April 25, 2017 11:51 AM
To: Marisol Garcia ([b) (6)]@frenchangel59.com)
Cc: [b) (6)]
Subject: two questions

Hi Marisol,

Would it be ok for [b) (6)] to attend the dinner tomorrow at 7pm with Ike, Jared etc?

Do you know the names of the ceo's that want to attend with Ike on Thursday here at VA for the Potus event? The Secretary mentioned – [b) (6)] and [b) (6)]

Thanks

[b) (6)] MBA
Special Advisor to the Secretary

Department of Veterans Affairs

202-461-[b) (6)]

202-834-[b) (6)]

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]va.gov]
Sent: 4/25/2017 10:58:45 PM
To: 'drshulkin' [drshulkin@aol.com]
Subject: FW: [EXTERNAL] RE: two questions

-----Original Message-----
From: Marisol Garcia [redacted]frenchangel59.com]
Sent: Tuesday, April 25, 2017 06:29 PM Eastern Standard Time
To: [redacted]
Cc: [redacted]
Subject: RE: [EXTERNAL] RE: two questions

Yes. We have [redacted] as attending. Thank you

From: [redacted] [mailto[redacted]va.gov]
Sent: Tuesday, April 25, 2017 12:25 PM
To: 'Marisol Garcia'
Cc: [redacted]
Subject: RE: [EXTERNAL] RE: two questions

Dr. Shulkin's wife – [redacted] Shulkin

From: Marisol Garcia [mailto:[redacted]frenchangel59.com]
Sent: Tuesday, April 25, 2017 12:24 PM
To: [redacted]
Cc: [redacted]
Subject: [EXTERNAL] RE: two questions

I am sorry who is [redacted]

We are trying to get the names of the CEO's as soon as possible.

Thank you

From: [redacted] [mailto[redacted]va.gov]
Sent: Tuesday, April 25, 2017 11:51 AM
To: Marisol Garcia ([redacted]@frenchangel59.com)
Cc: [redacted]
Subject: two questions

Hi Marisol,

Would it be ok for [redacted] to attend the dinner tomorrow at 7pm with Ike, Jared etc?

Do you know the names of the ceo's that want to attend with Ike on Thursday here at VA for the Potus event? The Secretary mentioned – [redacted] and [redacted]

Thanks

AMERICAN OVERSIGHT

(b) (6) [redacted] MBA
Special Advisor to the Secretary
Department of Veterans Affairs
202-461-(b) (6) [redacted]
202-834-(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 5/3/2017 12:48:32 AM
To: (b) (6) @gmail.com
Subject: Re: Senate Accountability Bill

That's good news.

-----Original Message-----
From: Darin Selnick <(b) (6) @gmail.com>
To: David Shulkin <Drshulkin@aol.com>
Sent: Tue, May 2, 2017 7:12 pm
Subject: Senate Accountability Bill

I am told by Rubio staff to keep this confidential, but there will be a surprise announcement by noon tomorrow on an agreed upon accountability bill sponsored by Rubio, Tester and Isakson.

Darin

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 5/2/2017 11:12:00 PM
To: David Shulkin [Drshulkin@aol.com]
Subject: Senate Accountability Bill

I am told by Rubio staff to keep this confidential, but there will be a surprise announcement by noon tomorrow on an agreed upon accountability bill sponsored by Rubio, Tester and Isakson.

Darin

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/29/2017 2:35:05 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: This was the clip that they played introducing me Thursday

That was so perfect

Sent from my iPad

On Apr 28, 2017, at 7:00 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Miguel found this on YouTube and surprised me as part of the intro to my opening session
>
> https://m.youtube.com/watch?v=dhjGOXeWRDM
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/28/2017 11:00:25 PM
To: Drshulkin@aol.com
Subject: This was the clip that they played introducing me Thursday

Miguel found this on YouTube and surprised me as part of the intro to my opening session

https://m.youtube.com/watch?v=dhjGOXeWRDM

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/20/2017 2:47:54 AM
To: brucem(b) (6)@mac.com
Subject: Re: [EXTERNAL] Forwarding Email with Attachments on Behalf of (b) (6) MD - Salick Comprehensive Diabetes Centers Inc.

Sounds good- Let me see what he proposes specifically and forward to you-

David

-----Original Message-----
From: Bruce Moskowitz <(b) (6)mac.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Wed, Apr 19, 2017 7:45 pm
Subject: Re: [EXTERNAL] Forwarding Email with Attachments on Behalf of (b) (6) MD - Salick Comprehensive Diabetes Centers Inc.

I know him very well. Perhaps when you get these offers I can assist in nicely telling them if they want to donate their expertise great.

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 19, 2017, at 7:11 PM, David shulkin <Drshulkin@aol.com> wrote:

> Bruce- any thoughts on this before I respond?
>
> David
> Forwarding Email with Attachments on Behalf of (b) (6) MD - Salick Comprehensive Diabetes Centers Inc.
>
> > Dear Dr. Shulkin,
> >
> > Forwarding the attached to you on behalf of (b) (6) M.D. as follows:
> >
> > 1. Letter Dated April 19, 2017
> > 2. (b) (6) M.D. - Bio
> > 3. Salick Comprehensive Diabetes Centers, Inc. – Executive Summary
> >
> > I have also listed Dr. (b) (6) contact information:
> >
> > (b) (6) M.D.
> > Chairman of the Board
> > Chief Executive Officer
> > Salick Comprehensive Diabetes Centers, Inc.
> > 9777 Wilshire Boulevard, Suite 512
> > Beverly Hills, California 90212
> > Direct: 310-967-(b) (6) Fax: 310-967-(b) (6)
> > Mobile: 310-729-(b) (6) 310-729-(b) (6)
> > (b) (6) aol.com
> >
> > Please respond directly to (b) (6) at: (b) (6) aol.com
> >
> > Thank you.

AMERICAN OVERSIGHT

Sincerely,

Sent Via Assistant's Email
(b) (6)
Executive Assistant to: Dr. (b) (6)
Salick Comprehensive Diabetes Centers, Inc.
9777 Wilshire Boulevard, Suite 512
Beverly Hills, California 90212
(b) (6) salickcenters.com
310-967-(b) (6) (O)
310-967-(b) (6) (Fax)

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<April 19 2017 Shulkin Letter.pdf>

<(b) (6) MD Bio.pdf>

<SCDC Executive Summary.pdf>

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/19/2017 11:45:31 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: [EXTERNAL] Forwarding Email with Attachments on Behalf of (b) (6) MD - Salick Comprehensive Diabetes Centers Inc.

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Sent from my iPad
Bruce Moskowitz M.D.

On Apr 19, 2017, at 7:11 PM, David shulkin <Drshulkin@aol.com> wrote:

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> Chairman of the Board
>
> Chief Executive Officer
>
> Salick Comprehensive Diabetes Centers, Inc.
>
> 9777 Wilshire Boulevard, Suite 512
> Beverly Hills, California 90212

AMERICAN OVERSIGHT

Direct: 310-967-[redacted] Fax: 310-967-[redacted]
Mobile: 310-729-[redacted] 310-729-[redacted]
[redacted]aol.com

Please respond directly to [redacted] at: [redacted]aol.com

Thank you.

Sincerely,

Sent Via Assistant's Email

[redacted]
Executive Assistant to: Dr. [redacted]
Salick Comprehensive Diabetes Centers, Inc.
9777 Wilshire Boulevard, Suite 512
Beverly Hills, California 90212
[redacted]salickcenters.com
310-967-[redacted] (O)

310-967-[redacted] (Fax)

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<April 19 2017 Shulkin Letter.pdf>
<[redacted] MD Bio.pdf>
<SCDC Executive Summary.pdf>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 11:11:23 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Fwd: [EXTERNAL] Forwarding Email with Attachments on Behalf of (b) (6) MD - Salick Comprehensive Diabetes Centers Inc.
Attachments: April 19 2017 Shulkin Letter.pdf; Untitled attachment 04290.htm; (b) (6) MD Bio.pdf; Untitled attachment 04293.htm; SCDC Executive Summary.pdf; Untitled attachment 04296.htm

Bruce- any thoughts on this before I respond?

David
Forwarding Email with Attachments on Behalf of (b) (6) MD - Salick Comprehensive Diabetes Centers Inc.

Dear Dr. Shulkin,

Forwarding the attached to you on behalf of (b) (6) M.D. as follows:

1. Letter Dated April 19, 2017
2. (b) (6) M.D. - Bio
3. Salick Comprehensive Diabetes Centers, Inc. – Executive Summary

I have also listed Dr. (b) (6) contact information:

(b) (6) M.D.
Chairman of the Board

Chief Executive Officer

Salick Comprehensive Diabetes Centers, Inc.

9777 Wilshire Boulevard, Suite 512
Beverly Hills, California 90212
Direct: 310-967-(b) (6) Fax: 310-967-(b) (6)
Mobile: 310-729-(b) (6) 310-729-(b) (6)
(b) (6) aol.com

Please respond directly to (b) (6) at: (b) (6) aol.com

AMERICAN OVERSIGHT

Thank you.

Sincerely,

Sent Via Assistant's Email

(b) (6)
Executive Assistant to: Dr. (b) (6)
Salick Comprehensive Diabetes Centers, Inc.
9777 Wilshire Boulevard, Suite 512
Beverly Hills, California 90212
(b) (6) salickcenters.com
310-967-(b) (6) (O)

310-967-(b) (6) (Fax)

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SALICK

COMPREHENSIVE DIABETES CENTERS, INC.

April 19, 2017

Via Priority Federal Express and Email

David Shulkin, M.D.
Secretary of Veteran's Affairs
Department of Veteran's Affairs
810 Vermont Avenue, NW
Washington DC 20420

Dear David:

Congratulations on your appointment as the head of the Veterans Administration! I recently called (b) (6) and (b) (6), both dear friends of ours, so that I could get your private email, and quickly speak to you, to avoid inevitable delays in governmental systems. Stan, Steve, and I agree that there is no better person than you to run the Veterans Administration health care system, with your background, credibility, and experience in all aspects of medicine.

I remember being involved with you a number of times when I was back East, negotiating with a variety of New York and New Jersey health systems including Continuum (Beth Israel, Maimonides) and Montefiore Medical Center and adjoining areas. My company, Salick Healthcare, Inc. (SHC), was one of your first clients for Doctor Quality, and I know we benefited from our mutual relationship as we both sought to increase transparency in health care.

As you may remember, I have been a pioneer in the creation of successful comprehensive outpatient diagnostic and treatment centers for catastrophic diseases such as cancer, end-stage renal disease (ESRD), and now diabetes mellitus, for the past 50+ years. I was able to open the first 24/7 outpatient comprehensive cancer center at Cedars Sinai Medical Center in Los Angeles, subsequently developing 18 cancer centers around the USA and eventually selling my company for $500mm to Astra Zeneca. After leaving Astra Zeneca because I rejected an emeritus position, I continued as Bentley Health Care for several years. Throughout my career, I have dealt with private, for-profit, academic centers, governmental agencies such as the National Health Service (NHS) in the UK, CMS (Medicare), and the archdioceses of New York and Brooklyn, and the Daughters of Charity in California.

I have continued to explore the establishment of Salick Health Care-type facilities at academic centers and private carriers throughout the country. I have focused my attention to the diagnosis and treatment of diabetes mellitus, especially its microvascular complications, which I now believe is, in my opinion, the most important and catastrophic illness, both for patient morbidity, mortality, and increasing financial costs. I was offered the CEO position at Harvard's Joslin Clinic in Boston by its then CEO and board, approximately five years ago. I rejected this offer because Joslin did not provide the kind of comprehensive approach which I had already

9777 WILSHIRE BOULEVARD, SUITE 512, BEVERLY HILLS, CALIFORNIA 90212
PHONE 310.967.(b) (6) FAX 310.967.(b) (6)

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developed at Salick Health Care. I have spent the last several years learning more about the disease and care delivery in multiple settings, and have met with many health care providers and academic centers throughout the country, to present my new paradigm to greatly improve the quality and lower the cost of care, similar to the methods I had employed at SHC.

I was dismayed to learn, having participated in both teaching and research at the VA-Sawtelle system in Los Angeles during my training, is the tremendous incidence of diabetes and complications of diabetes in the Veteran population, likely the single biggest disease driver of morbidity and costs for the VA. I believe I could add my methodology to the VA system with dramatic improvements in both the cost and quality of care of the disease. I could also significantly develop a capitated program with assumption of financial risk, based on practice guidelines and outcome measurements ("value health") as I have done at my SHC facilities. I have already discussed with a leading health care insurance provider to have them support me in my risk assumption.

I am committed to my successful model of diagnosis and treatment of catastrophic illness, and am confident we can be successful in working together using this model to provide all aspects of diabetic care to patients with diabetes mellitus (Type 1 and Type 2).

I would very much like to discuss a potential relationship with the VA. I have already met with some of the VA leadership in diabetes in Washington DC, including Leonard Pogach and Rajiv Patel two or three years ago. Dr. Patel recommended that it would be useful for me to meet with the Department of Defense (DOD), since their system of health care services was a very different system from the VA. He thought I might also provide a combined proposal to the DOD and the VA. I have also met with Mr. Guy Kiyokawa of the DOD at the Pentagon, and with senior officials of their own insurance provider, TriCare. I was accompanied to these meetings by members of my team, and with Congressman Henry Waxman, a long-time consultant and friend. I had follow up phone conferences with all of them. I also met with Congressman Mac Thornberry, Chairman of the House Armed Services Committee, in Washington D.C. My staff has also had discussions with Representative Kay Granger, who is the Chairperson of the House Defense Appropriations Subcommittee in Health Care.

I am hoping to speak with you to share details of my program, and to meet with you. Salick Comprehensive Diabetes Centers, Inc. ("SCDC"), is a national diabetes program, which includes a network of comprehensive outpatient diabetes centers in affiliation with academic centers for inpatient services, research, and teaching, and a national dialysis provider of dialysis services for ESRD. The network will be affiliated with academic medical centers and/or major for-profit providers of health care services. The network will focus on the prevention, diagnosis, and treatment of all forms of diabetes mellitus, with the major emphasis being on the microvascular complications of diabetes (retinopathy, cardiovascular disease and peripheral cardiovascular disease, and ESRD). Approximately 93% of the $250 billion annual cost of health care in diabetes are secondary to these complications.

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(b) (6) and (b) (6) who are very familiar with all my programs, send their best wishes to you.

Best personal regards.

Very truly yours,

(b) (6)
M.D.
Chairman of the Board
Chief Executive Officer
Salick Comprehensive Diabetes Centers, Inc.

BS:GS
encl: (b) (6) M.D. Bio; Executive Summary

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[redacted] M.D.
Chairman of the Board and Chief Executive Officer
Salick Comprehensive Diabetes Centers, Inc.

Dr. [redacted] is widely recognized as a visionary, pioneer, and leading expert in the field of disease-state management. The founder and former Chairman and CEO of Salick Health Care, Inc., he developed industry-changing concepts and solutions that fundamentally transformed how patients with chronic and catastrophic illnesses are diagnosed and treated. While leading Salick Health Care, Inc., he created a managed care subsidiary, the first to offer fixed-price insurance products for the treatment of catastrophic diseases such as cancer and end-stage renal disease. He established a series of practice guidelines and outcome measurements for cancer treatment which were instituted nationwide at the eleven Comprehensive Cancer Centers, and the eight Comprehensive Breast Centers operated by Salick Health Care, Inc. These diagnostic and treatment centers were open 24 hours a day, seven days a week, providing quick, user-friendly, and high quality out-patient care in a cost-effective manner.

In 1997, Salick Health Care, Inc. was sold to Zeneca PLC (Astra-Zeneca). [redacted] then created Bentley Health Care, providing diagnostic and therapeutic services to patients with chronic and catastrophic illness including cancer, end-stage renal disease, and AIDS. Bentley Health Care, Inc. and all of [redacted] health care companies, are dedicated to advancing the field of disease-state management through innovative and unique solutions to patients, physicians, and payors seeking quality care and cost-effective, disease-state programs.

Based on his disease-specific paradigm that he has previously pioneered, he developed the concept of Comprehensive Cardiovascular Centers. Salick Cardiovascular Centers, Inc. in affiliation with Private Equity Partners, proposed a broad range of innovative services for the diagnosis and treatment of cardiovascular disease (including cerebrovascular, coronary artery, coronary heart and peripheral vascular disease) and cardiovascular end-stage renal disease on an out-patient basis, with in-patient affiliations. These centers will offer state-of-the-art procedures and techniques for the treatment and diagnosis of cardiovascular disease, including surgery, angioplasty, angiography, electrophysiologic procedures, sophisticated radiology, and other diagnostic testing and medical services. Leading practitioners, researchers and educators in the cardiovascular field indicated their desire to join [redacted] to develop the Centers on a national basis. These essential services will be available to patients, physicians and payors in a multidisciplinary, high quality, user-friendly, cost-efficient environment, open 24 hours a day, seven days a week and will be incorporated with the Salick Comprehensive Diabetes Centers, Inc.

In addition, [redacted] worked with Members of the Harvard Business School and Harvard Medical School Faculty in developing a plan for a Personalized Medicine Molecular Biology entity headed by Dr. [redacted]

[redacted] received his B.S. degree from Queens College, New York in 1960, and his M.D. from the University of Southern California in 1964. He completed his internship and residency in Internal Medicine at Cedars-Sinai Medical Center and a National Institutes of Health Postdoctoral Fellowship in Nephrology at Cedars-Sinai Medical Center and the University of California, Los Angeles. [redacted] is currently licensed in California, New York, and New Jersey. He has served on the board of the Queens College Foundation, and Crossroads School for Arts and Sciences in Santa Monica. He is and has been a member of the Visiting Committee and the Leadership Council of the Harvard School of Public Health.

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He is a regular visiting lecturer at and has been a member of the Healthcare Initiative Advisory Board and the Centennial Committee of the Harvard Business School. In 2005, [redacted] served on both the Harvard Business School panel for the Healthcare Innovation and Opportunities in Southeast Asia and also was a guest speaker for the India and Its Neighbors Conference. He served on the Board of Directors of Nephros, Inc. (AMEX:NEP) from 2005 to 2007 and in addition, he served as a member of the Board of Trustees for the United States Equestrian Team Foundation from 1991 to 2011. In 2004, [redacted] established a fellowship at Harvard School of Public Health to provide annual scholarships for selected students pursuing studies related to cancer and/or cardiovascular disease. He also provides funds for fellowships and scholarships at Yeshiva University, Queens College, and Stuyvesant High School.

In 2010, [redacted] was offered the position of Chief Executive Officer of Harvard's Joslin Clinic by its Board of Trustees, an offer that [redacted] declined. [redacted] is presently working on the development of a nationwide program of Comprehensive Diabetes Centers. [redacted] received his academic appointment as Professor of Medicine, Cedars-Sinai Medical Center on January 1, 2017.

[redacted] and his wife Gloria reside in Los Angeles and New York. They have three daughters who have each completed graduate school in New York and post-graduate school in New York and in Washington, DC. [redacted] and [redacted] presently have five grandchildren.

Tribute by Shlomo Melmed, M.D.
Honoring [redacted] M.D. – Alumnus of the Year
Cedars-Sinai Alumni Association
Cedars-Sinai Medical Center
December 2, 2010

It is a pleasure for me to honor [redacted] here tonight. [redacted] has had a major impact nationally and internationally in the development of new clinical programs for the diagnosis and treatment of patients in many areas of medicine including Nephrology, Cancer, Organ Transplant, Cardiovascular Disease, and Personalized Medicine. He is a world renowned medical entrepreneur whose companies have striven to provide compassionate and advanced care to patients with catastrophic diseases in a user-friendly, high quality outpatient care in a cost effective manner. He early on realized the benefits of a 24-hour a day, outpatient diagnosis and treatment center. His clinics developed standards for care of cancer treatments including a vast database of cancer drug use and treatment outcomes such as chemotherapy for colon cancer, bone marrow transplants for breast cancer, and the use of anti-nausea drugs. He has been intimately involved in developing these centers with academic medical centers and governments throughout the United States, the United Kingdom, Europe, Israel, and Southeast Asia. Proudly, he developed the first Cancer Center at Cedars-Sinai, dedicated to excellence in patient care, and delivery of 24/7 service.

Regarded by fellow professionals as one of the nation's leading and most innovative health care entrepreneurs, [redacted] also boasts an impressive career as a physician and leader of many national civic causes. He has served on multiple committees at Harvard University School of Public Health, Business School, and Medical School. He has served on the National Advisory Board for the National Kidney Foundation (1988-1990), was a member of the Board of Directors for American Woman's Economic Development Corporation (1990-1991) and Nephros, Inc. (2005-2007), and was on the Board of Trustees for the Hereditary Disease Foundation (1975-1985).

[redacted] has been instrumental in providing a unique model of innovative and effective treatment for patients with catastrophic diseases. He is a world renowned health care innovator who has had tremendous impact on national and worldwide medical delivery practices. I congratulate him and Glo for this well deserved honor, as a veteran member of the Cedars-Sinai family. Cedars-Sinai is proud of you, [redacted] and we wish you good health and energy to continue contributing to society with your unique passion and energy.

[redacted], MD
Senior Vice President of Academic Affairs, Dean of the Medical Faculty
Cedars-Sinai Medical Center

Rev: April 19, 2017

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SALICK

COMPREHENSIVE DIABETES CENTERS, INC.

EXECUTIVE SUMMARY

(b) (6), (b) (4)

[redacted]

STRICTLY CONFIDENTIAL

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(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (4)

[redacted]

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 5/3/2017 3:00:09 AM
To: brucem(b) (6) @mac.com
CC: David Shulkin [drshulkin@aol.com]
Subject: Fwd: Top 5 disability problems in our patients

Bruce - you are right to focus on Tinnitus- please see below, the top disability. The rest of the 9 disability areas are listed. Let's try to schedule the call with the ENT researcher next week - thanks

Sent from my iPhone

Begin forwarded message:

From: "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
Date: May 2, 2017 at 10:53:15 PM EDT
To: 'Poonam Alaigh' <(b) (6) hotmail.com>
Subject: FW: Top 5 disability problems in our patients

Sent with Good (www.good.com)

-----Original Message-----
From: Crump, Regan
Sent: Tuesday, May 02, 2017 08:58 AM Eastern Standard Time
To: Alaigh, Poonam, M.D.
Cc: (b) (6) Hyduke, Barbara; (b) (6) (b) (6)
Subject: Top 5 disability problems in our patients

Dr. Alaigh:

Here are the top 5, plus the next 5. We used the latest update from VBA in their end of year FY2014 data and found the following most prevalent Service Connected Disabling conditions. Recent conversations with VBA indicate that these conditions remain the most common conditions. They are specifically rated as disabling and compensable by VBA, though they do not represent a list of the top most expensive chronic disabilities in the general VHA population. The most expensive conditions will be available tomorrow.

Diagnosis	Description	Category	Number of Diagnoses	Most Frequent Rating Level
6260	Tinnitus, Recurrent.	The Ear	1,271,638	10%
9411	Posttraumatic Stress Disorder.	Neurological Conditions And Convulsive Disorders	772,274	70%
7913	Diabetes Mellitus.	The Endocrine System	482,112	20%
5237	Lumbosacral Or Cervical Strain.	The Musculoskeletal System	436,328	10%

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8520	Sciatic Nerve, Paralysis.	Neurological Conditions And Convulsive Disorders	435,754	10%
5260	Leg, Limitation Of Flexion.	The Musculoskeletal System	405,995	10%
5242	Degenerative Arthritis.	The Musculoskeletal System	331,252	10%
6100	Hearing Loss	The Ear	318,213	10%
5010	Arthritis, Due To Trauma.	The Musculoskeletal System	282,611	10%
5271	Ankle, Limited Motion.	The Musculoskeletal System	260,711	10%

Note that these conditions are the most prevalent service-connected conditions. They do not include conditions that are not related the veteran's service. The list does not make any adjustment for severity of the condition, or the cost to treat the condition.

-----Original Message-----
From: Alaigh, Poonam, M.D.
Sent: Monday, May 01, 2017 06:37 PM Eastern Standard Time
To: Crump, Regan
Subject: RE: Top 5 disability problems in our patients

Any update on this?

Sent with Good (www.good.com)

-----Original Message-----
From: Crump, Regan
Sent: Saturday, April 29, 2017 10:46 PM Eastern Standard Time
To: Alaigh, Poonam, M.D.
Subject: RE: Top 5 disability problems in our patients

Thank you.

Regan

From: Alaigh, Poonam, M.D.
Sent: Saturday, April 29, 2017 4:08 PM
To: Crump, Regan; Hyduke, Barbara
Subject: RE: Top 5 disability problems in our patients

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Let's just use your data based on VBA info

Sent with Good (www.good.com)

-----Original Message-----
From: Crump, Regan
Sent: Saturday, April 29, 2017 01:38 PM Eastern Standard Time
To: Alaigh, Poonam, M.D.; Hyduke, Barbara
Subject: RE: Top 5 disability problems in our patients

We can and will use our VBA data on service-connected condition determination to answer the question by Wednesday. Ours is based on official disability determinations for veterans by VBA, not utilization or cost.

If you want prevalence data on the conditions or diagnoses noted when the enrolled Veteran population presents for treatment, the data source for that question rests within 10P4, Patient Care Services, or in 10E, with the analytics group led by Dr. Joe Francis.

Would you like us to ask them or do you want to just ask them directly to get that other more proximal assessment on top 5 disability problems? You asking might clarify the importance.

Regan

Sent with Good (www.good.com)

-----Original Message-----
From: Alaigh, Poonam, M.D.
Sent: Saturday, April 29, 2017 11:47 AM Eastern Standard Time
To: Hyduke, Barbara; Crump, Regan
Subject: RE: Top 5 disability problems in our patients

Can we look at it both ways and that way can also see if there is an overlap

Sent with Good (www.good.com)

-----Original Message-----
From: Hyduke, Barbara
Sent: Saturday, April 29, 2017 10:23 AM Eastern Standard Time
To: Crump, Regan; Alaigh, Poonam, M.D.
Subject: RE: Top 5 disability problems in our patients

Dr. Alaigh - please advise - thanks

AMERICAN OVERSIGHT

From: Crump, Regan
Sent: Saturday, April 29, 2017 10:14 AM
To: Hyduke, Barbara; Alaigh, Poonam, M.D.
Subject: RE: Top 5 disability problems in our patients

Are you talking about service connected disabilities or do you mean most costly patients with multiple chronic disabling conditions? What's the context so I ask the right question?

Sent with Good (www.good.com)

-----Original Message-----
From: Hyduke, Barbara
Sent: Saturday, April 29, 2017 09:31 AM Eastern Standard Time
To: Alaigh, Poonam, M.D.; Crump, Regan
Subject: RE: Top 5 disability problems in our patients

Sure- will tap Regan's team for this information

-----Original Message-----
From: Alaigh, Poonam, M.D.
Sent: Saturday, April 29, 2017 9:31 AM
To: Hyduke, Barbara
Subject: Top 5 disability problems in our patients

Can we get information on that

Sent with Good (www.good.com)

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/20/2017 1:45:29 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David Shulkin [drshulkin@aol.com]
Subject: Re: Internship slots

I have had some initial discussion with our Office of Academic Affairs. Unfortunately our lead for this area has been diagnosed with a grave illness so things have slowed a bit. However, some members of his team are coming to meet me in DC early May when I was planning to discuss with them in person the possible opportunities since you had secured a funding source. If you think its time sensitive on your end, I will expedite the discussions, otherwise we should have more information on this early May.

From: Bruce Moskowitz <(b) (6) mac.com>
Sent: Wednesday, April 19, 2017 7:33 AM
To: Poonam Alaigh
Subject: Internship slots

Any update?

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/24/2017 7:12:30 PM
To: brucem(b) (6) @mac.com
Subject: Re: Thursday

I am trying to get the executive order that they have prepared so we can see it.

I am pretty sure they are going to use the one that established an Accountability Office for VA but I am confirming this.

-----Original Message-----
From: Bruce Moskowitz <(b) (6) mac.com>
To: David shulkin <drshulkin@aol.com>
Sent: Mon, Apr 24, 2017 1:34 pm
Subject: Thursday

What bill is being signed

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/24/2017 5:33:17 PM
To: David shulkin [drshulkin@aol.com]
Subject: Thursday

What bill is being signed

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/21/2017 1:08:29 AM
To: Bruce Moskowitz [(b) (6) mac.com]; Marc Sherman [(b) (6) gmail.com]
CC: L Perl [(b) (6) gmail.com]; David shulkin [drshulkin@aol.com]; IP [(b) (6) frenchangel59.com]
Subject: Re: Kaiser Permanente

Bruce, I have reviewed the article and know that we at the VA have similar pharmacist detailing programs, controlled substance contracts, dispensing of these medications in small quantities, pain management teams, and opioid prescribing reviews. But I do think there is significant value in getting our VA team together with the Kaiser team on the phone so that we can share our mutual practices for additional learning. This is especially a critical part of our suicide prevention program. Really appreciate this, as we collectively work on improving the care for our Veterans.

How do you suggest proceeding Bruce?

From: Bruce Moskowitz <(b) (6) mac.com>
Sent: Thursday, April 20, 2017 1:21 PM
To: Marc Sherman
Cc: L Perl; David shulkin; Poonam Alaigh; IP
Subject: Re: Kaiser Permanente

I have all the information and can set up a call after article is reviewed

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 20, 2017, at 12:50 PM, Marc Sherman <(b) (6) gmail.com> wrote:

> Should we first have (b) (6) introduce is to the person in charge of that effort and pick his/her brain. Then we can put a plan together from what we learn.
>
> Marc Sherman
> (202) 758-(b) (6)
>
> On Apr 20, 2017 11:04 AM, "Bruce Moskowitz" <(b) (6) mac.com> wrote:
> This is a good wake up call. Our academic partner Kaiser Permanente has in place an important program to prevent and treat opioid addiction since 2010!!
> We need to form a committee see what is available and borrow it. This would be the best chance to fix problems in an expedited way. The article appeared in the NEJM today.
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/20/2017 10:50:20 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Kaiser Permanente

Ill review this weekend

We are part if christies committee on opiod addiction and can help lead the way

Sent from my iPhone

> On Apr 20, 2017, at 11:04 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> This is a good wake up call. Our academic partner Kaiser Permanente has in place an important program to prevent and treat opioid addiction since 2010!!
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>
> <Addressing the Opioid Epidemic-Opportunities in the Postmarketing Setting.pdf>
>
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/20/2017 10:49:35 PM
To: [redacted] [redacted]va.gov]
Subject: Fwd: Kaiser Permanente
Attachments: Untitled attachment 04327.pdf; Untitled attachment 04330.htm

Print

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <[redacted]mac.com>
> **Date:** April 20, 2017 at 11:04:23 AM EDT
> **To:** David shulkin <drshulkin@aol.com>, Poonam Alaigh <[redacted]hotmail.com>
> **Cc:** IP <[redacted]frenchangel59.com>, L Perl <[redacted]gmail.com>, mbs[redacted]@gmail.com
> **Subject: Kaiser Permanente**
>
> This is a good wake up call. Our academic partner Kaiser Permanente has in place an important program to prevent and treat opioid addiction since 2010!!
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AMERICAN OVERSIGHT

Addressing the Opioid Epidemic — Opportunities in the Postmarketing Setting

Bruce M. Psaty, M.D., Ph.D., and Joseph O. Merrill, M.D., M.P.H.

The Food and Drug Administration (FDA) recently developed a multipart action plan in response to the opioid epidemic.[1] As part of that initiative, it invited recommendations from the National Academy of Medicine about a regulatory framework that might allow public health considerations to be factored into drug-approval decisions. The FDA, however, may already be able to take some public health–related actions in the postmarketing setting, including those related to the generation of evidence and the regulation of marketing.

The preapproval evaluation of drugs is meant to ensure that they are safe and effective for their intended use. Nonetheless, widespread use of approved drugs often leads to identification of safety issues, including rare adverse events that may not be detected in preapproval trials. Black-box warnings are not uncommon, and a small percentage of drugs are withdrawn from the market. Prescription opioids, however, are outliers when it comes to safety: since 1999, they have been implicated in 165,000 overdose deaths.

By the mid-20th century, legal restrictions on opioid prescribing had led to widespread undertreatment of pain. In the late 1980s and early 1990s, it was argued "largely on moral grounds" that opioids should be available for chronic pain.[2] The management model that was adopted was based on the success of opioids for acute and end-of-life pain: a "titrate-to-effect" principle was applied, and a numerical rating became the chief metric. Pain came to be known as the "fifth vital sign."

In this setting, the combination of aggressive marketing of prescription opioids by manufacturers, promotion by marquee professors, and endorsement by pain societies contributed to a cultural transformation. The long-standing convention of trying to avoid opioids for chronic pain gave way to a new culture in which the drugs were favored for chronic noncancer pain, despite a lack of evidence to support their use.

A 2009 article summarized the promotion of OxyContin (oxycodone) by Purdue Pharma between 1996 and 2001.[3] Those efforts included hosting 40 all-expenses-paid speaker-training conferences for 5000 practitioners, as well as 20,000 pain "education" programs. Purdue used physician profiling to target high-volume opioid prescribers with sales representatives who were encouraged by a generous bonus system. Branded promotional items and free starter coupons for patients were available. The company also misrepresented the addiction risk posed by OxyContin in its materials for patients and physicians.[3]

The campaign paid off: annual sales increased from $48 million to $1.1 billion. Misleading statements about addiction risk amounted to misbranding, and they eventually cost the manufacturer and executives $634 million in fines. But evidence-based treatment for opioid addiction in patients whose addictions derived from treatment for chronic pain has been slow to emerge. And promotional efforts continue — even now, a manufacturer's coupon for 80% off OxyContin is available online.

In the United States, direct-to-consumer advertising promoting "a pill for every ill" has helped create an epidemic of prescription-drug use, with U.S. sales reaching $425 billion in 2015. As part of that trend, a whole generation of physicians was trained to turn readily to opioids when patients talked about pain. Between 1999 and 2009, both opioid sales and opioid-related deaths increased fourfold. In the process, some clinics unintentionally became pill mills. At our clinic in Seattle, the low threshold for prescribing opioids attracted some young, healthy drug users who considered it an easy place to obtain narcotics.

Even today, the risk–benefit profile of opioids used for chronic pain remains unknown. A recent review identified no studies lasting longer than 1 year that evaluated pain, function, or quality of life as a primary outcome.[4] The harms associated with opioid use, however, are well documented and often dose-dependent. They include abuse, addiction, hyperalgesia, overdose, fracture, pneumonia, erectile dysfunction, motor vehicle crashes, cardiovascular events, and death. Drug labels need to point clearly to the known

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VA-19-0790-D-000185
DS 00001847

harms and limited evidence of efficacy for long-term opioid use, especially in high doses.

When safety signals are detected, the FDA can mandate postmarketing studies, including clinical trials, to better assess the safety of approved products. Long-term, placebo-controlled, randomized studies of opioids are difficult to conduct, however, because of high dropout rates. An unanswered question, for example, is whether to start patients with chronic pain on short-acting or long-acting opioids. Although long-acting agents are valuable for asymptomatic conditions such as hypertension, in which patients may not adhere to frequent dosing, they may be unnecessary in treating pain. And given that function is also an outcome of interest, do long-acting or extended-release opioids add value or just toxicity? In this case, the FDA could call for a randomized trial similar to the PRECISION trial, which it mandated to assess the cardiovascular safety of the nonsteroidal antiinflammatory drug celecoxib.[5] Also needed, but outside the jurisdiction of FDA-mandated safety studies, are trials at the health-system level that evaluate the best methods for reducing opioid prescribing while retaining patients in care and adequately controlling their pain.

The epidemic of opioid abuse and addiction has its origins in the pharmaceutical industry and the medical community. The FDA regulates industry, not medical practice. It may be possible, however, for the agency to use labeling changes to affect marketing and promotion — and thereby influence prescribing patterns.

For controlled substances that pose a high risk of addiction and abuse, the FDA should have the power to limit or prohibit prescriber profiling and off-label promotion as well as the use of coupons or other forms of direct-to-consumer marketing. In light of the ongoing opioid epidemic, the rationale for permitting aggressive sales efforts is unclear. Although the FDA's authority to regulate off-label marketing is the subject of several active court cases, opioids represent a special case, given the devastation and death they have caused. First Amendment arguments for reducing the amount of evidence required for marketing drugs for off-label uses do not rise above the compelling public health arguments favoring limitations on opioid marketing. If the FDA were to require new statements on opioid labels about the absence of evidence of long-term safety and efficacy in order to limit or prohibit companies from marketing those drugs for off-label uses such as long-term treatment of chronic noncancer pain, physicians' prescribing options wouldn't necessarily be limited. If it's not clear that the FDA has the authority to limit the off-label marketing of controlled substances, Congress could expand the agency's authority to modify what has been one of the main drivers of the opioid epidemic.

Most interventions available to the FDA to limit opioid prescribing and abuse are no match for the force of the culture that emerged from the confluence of interests of industry, influential academics, and pain societies during the 2000s. Now that opioid prescribing is widespread, system-level and not simply individual-level interventions will be required to change medical practice.

Beginning around 2010, our clinic made several changes to improve the risk–benefit profile for management of chronic pain. We adopted controlled-substances agreements, implemented urine testing and prescription-drug–monitoring programs, convened an opioid review committee to assist clinicians with difficult cases, started using pharmacists to help oversee opioid prescriptions at the clinic level, and provided education, support, and access to pain-management specialists. More recently, we fully integrated medication-assisted treatment for addiction into the primary care setting, providing a crucial evidence-based tool for treating high-risk patients.

These system- and clinic-level activities have shifted the culture surrounding pain management in a way that could never have been accomplished by providing only continuing medical education about opioids to individual physicians. Reports describing the results of systemwide interventions at other facilities have come to similar conclusions. Reducing unnecessary exposure to opioids and improving physician education about pain management (not limited to opioid prescribing), as recommended in recent guidelines from the Centers for Disease Control and Prevention, represent additional and important primary prevention efforts.

Disclosure forms provided by the authors are available at NEJM.org.

From the Cardiovascular Health Research Unit (B.M.P.) and the Departments of Medicine (B.M.P., J.O.M.) and Epidemiology and Health Services (B.M.P.), University of Washington, and the Kaiser Permanente Washington Health Research Institute (B.M.P.) — both in Seattle.

1. Califf RM, Woodcock J, Ostroff S. A proactive response to prescription opioid abuse. N Engl J Med 2016;374:1480-5.
2. Ballantyne JC, Sullivan MD. Intensity of

AMERICAN OVERSIGHT
VA-19-0799-D-000186
DS_00001848

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/20/2017 5:21:34 PM
To: Marc Sherman [(b) (6) gmail.com]
CC: L Perl [(b) (6) gmail.com]; David shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]; IP [(b) (6) frenchangel59.com]
Subject: Re: Kaiser Permanente

I have all the information and can set up a call after article is reviewed

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 20, 2017, at 12:50 PM, Marc Sherman <(b) (6) gmail.com> wrote:

> Should we first have (b) (6) introduce is to the person in charge of that effort and pick his/her brain. Then we can put a plan together from what we learn.
>
> Marc Sherman
> (202) 758-(b) (6)
>
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AMERICAN OVERSIGHT

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CC: IP [(b) (6) frenchangel59.com]; L Perl [(b) (6) gmail.com]; mbs(b) (6) @gmail.com
Subject: Kaiser Permanente
Attachments: Untitled attachment 04338.pdf; Untitled attachment 04341.txt

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AMERICAN OVERSIGHT

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When safety signals are detected, the FDA can mandate postmarketing studies, including clinical trials, to better assess the safety of approved products. Long-term, placebo-controlled, randomized studies of opioids are difficult to conduct, however, because of high dropout rates. An unanswered question, for example, is whether to start patients with chronic pain on short-acting or long-acting opioids. Although long-acting agents are valuable for asymptomatic conditions such as hypertension, in which patients may not adhere to frequent dosing, they may be unnecessary in treating pain. And given that function is also an outcome of interest, do long-acting or extended-release opioids add value or just toxicity? In this case, the FDA could call for a randomized trial similar to the PRECISION trial, which it mandated to assess the cardiovascular safety of the nonsteroidal antiinflammatory drug celecoxib.[5] Also needed, but outside the jurisdiction of FDA-mandated safety studies, are trials at the health-system level that evaluate the best methods for reducing opioid prescribing while retaining patients in care and adequately controlling their pain.

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From the Cardiovascular Health Research Unit (B.M.P.) and the Departments of Medicine (B.M.P., J.O.M.) and Epidemiology and Health Services (B.M.P.), University of Washington, and the Kaiser Permanente Washington Health Research Institute (B.M.P.) — both in Seattle.

1. Califf RM, Woodcock J, Ostroff S. A proactive response to prescription opioid abuse. N Engl J Med 2016;374:1480-5.
2. Ballantyne JC, Sullivan MD. Intensity of

AMERICAN OVERSIGHT
VA-19-0799-D-000191
DS_00001853

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 3:28:50 PM
To: (b) (6) [(b) (6) gmail.com]

http://www.cbsnews.com/videos/va-secretary-david-shulkin-on-challenges-facing-the-agency/?ftag=CNM-00-10aab4i

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/25/2017 5:07:19 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Thinking about thursday

David,

We are working to get you the answers you need.

Please let me know what time we need to be available for the tour of Walter Reed.

Thank you,
Ike

-----Original Message-----
From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Tuesday, April 25, 2017 9:46 AM
To: Ike Perlmutter; Marc Sherman; Bruce Moskowitz; Laurie Perlmutter
Subject: Thinking about thursday

I want to use our time on thursday as valuable as possible - and trying to balance this with what is also a very full schedule that I already had planned- here are some suggestions- Id like your feedback:

I have a breakfast with all veteran service groups in the morning I cannot cancel - after that I have a long planned tour of Walter Reed thursday mid morning - ive been hearing about the amazing medical and rehab services they have for soldiers and they want to show it to me- one possibility would be for you all to join me

We can also set up brief meetings on

Inventory control

Telehealth

eMR planning

Access/Wait time issues

Apple

Facility planning

Would any of these be of particular interest?

Finally- i was thinking of holding a reception in the afternoon for you all and members of congress and wounded warriors- we have to be seated an hour before the president arrives (secret service requires) so i would limit it to 30 minutes

Too much to do in a day so i wanted to get your feedback

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/20/2017 12:23:45 AM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: From John Ullyot -- CBS News Response

That is great. Congratulations. The problem is so obvious, trying to hide from it just compounds the problem and PR nightmare. Very well done the way you handled it.

I had just seen the CBS piece and was about to email you as I was opening your email. I am looking forward to seeing the later edition to see if/how they handle it.

On Wed, Apr 19, 2017 at 6:59 PM, David shulkin <Drshulkin@aol.com> wrote:
Just had a major story tonight on cbs news - a story of a veteran waiting way too long for prosthetic legs- our PR team put out a draft statement on how we deliver the best care etc etc. i ripped it up and said I wanted to say that there were no excuses for this- see below and CBS's surprise at our response

We are sending a strong message to VA and the country that this is not acceptable

David

> **Subject:** FW: From John Ullyot -- CBS News Response
>
> Dr. Shulkin:
>
> See below response based on our conversation with you on the request from CBS News' David Martin we received this afternoon.
>
> As you can see, we informed the WH and they (b) (5) .
>
> FYI the reporter David Martin called us right back once he received it and said, "Just wanted you to know, this is an incredibly forthright statement. Congratulations."
>
> The piece will air on tonight's CBS Evening News.
>
> Thanks again for your prompt and clear direction to us on this inquiry.
>
> All the best,
>
> John U.
>
> ---
>
> **From:** "Hutton, James" <James.Hutton@va.gov>
> **Date:** Wednesday, April 19, 2017 at 4:06 PM
> **To:** "(b) (6) who.eop.gov" (b)(b) (6) who.eop.gov>, "(b) (6) who.eop.gov" <(b) (6) who.eop.gov>
> **Cc:** Department of Veterans Affairs Department of Veterans Affairs <john.ullyot@va.gov>, "Leinenkugel, Jake" <Thomas.Leinenkugel@va.gov>, "Tallman, Gary" <Gary.Tallman@va.gov>

AMERICAN OVERSIGHT

Subject: From John Ullyot -- CBS Response

Kaelan (from John Ullyot):

FYI -- per John's call with you right now:

CBS News (David Martin) is doing a piece for tonight's Evening News about a former USMC SgtMaj who is a double amputee and who has had to wait up to 3 months at a time (up to 6 separate occasions) for replacement prosthetics from VA Medical Center in Fayetteville NC, whereas the same Veteran happened to visit Walter Reed Medical Center (DoD) and received same-day service there for new prosthetics.

David knows we can't comment on a specific patient, but is asking for comment on why VA takes so much longer than DoD to take care of our Veteran amputees?

We spoke with Dr. Shulkin and, based on his input, we have drafted the following statement, attributed to the Department:

Statement by Department of Veterans Affairs

April 19, 2017

At VA, we do not believe Veterans should have to wait for care when they are in need, as in the case of this Veteran.

This President and this Secretary of Veterans Affairs stand committed to fixing wait-time issues at VA, and to providing our Veterans with the best possible care.

AMERICAN OVERSIGHT

VA has been under-resourced for a long time in this area, but that's no excuse – we own these issues and our job is fixing them as quickly as possible for our Veterans.

Thanks,

John U.

202-701-0138

James Hutton

Deputy Assistant Secretary (Acting)

Office of Public Affairs

Department of Veterans Affairs

810 Vermont Ave, NW

Washington, D.C. 20420

Office: 202-461-7558

Email: james.hutton@va.gov

Twitter: @jehutton

VA on Facebook . Twitter . YouTube . Flickr . Blog

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 10:59:58 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]; Marc Sherman [(b) (6) gmail.com]; David Shulkin [drshulkin@aol.com]
BCC: Poonam Alaigh [(b) (6) hotmail.com]
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Thanks again for your prompt and clear direction to us on this inquiry.

All the best,

John U.

From: "Hutton, James" <James.Hutton@va.gov>
Date: Wednesday, April 19, 2017 at 4:06 PM
To: "(b) (6) who.eop.gov" <(b) (6) who.eop.gov>, "(b) (6) who.eop.gov" <(b) (6) who.eop.gov>
Cc: Department of Veterans Affairs Department of Veterans Affairs <john.ullyot@va.gov>, "Leinenkugel, Jake" <Thomas.Leinenkugel@va.gov>, "Tallman, Gary" <Gary.Tallman@va.gov>
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Thanks,

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202-701-0138

James Hutton

Deputy Assistant Secretary (Acting)

Office of Public Affairs

Department of Veterans Affairs

810 Vermont Ave, NW

Washington, D.C. 20420

Office: 202-461-7558

Email: james.hutton@va.gov

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AMERICAN OVERSIGHT

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Sent: 4/20/2017 1:50:34 AM
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CC: Marc Sherman [(b) (6) gmail.com]; David shulkin [Drshulkin@aol.com]; L Perl [(b) (6) gmail.com]
Subject: Re: Thanks

Also, if you have some names of folks that would be good to be part of the Fraud task force, please send them along. I know Marc is also working on it as we add to a potential list of candidates.

From: Bruce Moskowitz <(b) (6) mac.com>
Sent: Wednesday, April 19, 2017 8:16 AM
To: IP
Cc: Marc Sherman; David shulkin; Poonam Alaigh; L Perl
Subject: Re: Thanks

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From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/19/2017 12:58:01 PM
To: David shulkin [Drshulkin@aol.com]
CC: mbs(b) (6) @gmail.com; IP [(b) (6) frenchangel59.com]
Subject: Re: Thanks

Yes and what I would recommend is a multi specialty panel. Also it needs to represent different geographic regions to be effective. Also it is a mix of seasoned active physicians in private practice and academic center practice combined with those who are in practice just a few years who are more tech savvy. They love the challenge and that is why they would donate their time.

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Sent: 4/19/2017 12:16:03 PM
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CC: Marc Sherman [(b) (6) gmail.com]; David shulkin [Drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]; L Perl [(b) (6) gmail.com]
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Sent: 4/19/2017 11:58:48 AM
To: 'Bruce Moskowitz' [(b) (6) mac.com]; 'Marc Sherman' [(b) (6) gmail.com]
CC: 'David shulkin' [Drshulkin@aol.com]; 'Poonam Alaigh' [(b) (6) hotmail.com]; 'L Perl' [(b) (6) gmail.com]
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Sent: 4/19/2017 1:50:21 AM
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> On Apr 18, 2017 4:38 AM, "Poonam Alaigh" <(b) (6) hotmail.com> wrote:
> Marc- it was so good catching up in a relaxed setting with an incredible ambiance where we could simply brainstorm and problem solve as we together bring about the transformation of the organization. Let's try to meet regularly, monthly if possible. Also, please send the proposed approach/plan as an attachment so that we can start to activate it. Thanks again, all of you are helping us serve our nations heroes better- and we can't possibly achieve what we are/will without your invaluable support and input.
>
> David and Poonam
>
> Sent from my iPhone
>
> > On Apr 17, 2017, at 9:28 PM, Marc Sherman <(b) (6) gmail.com> wrote:
> >
> > Thanks for the great conversation...And humoring me.
> >
> > Marc Sherman
> > (202) 758-(b) (6)

<Dinner Discussion Agenda 041717.docx>

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/19/2017 1:34:59 AM
To: David shulkin [Drshulkin@aol.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Thanks
Attachments: Dinner Discussion Agenda 041717.docx

Thanks for the responses. I got home so late last night I didn't get a chance to send the dinner agenda as promised...sorry Poonam -- see attached.

An EO on the competitive salaries could also have a dual benefit with some good White House PR impact as well as serving to solve your staffing leakage.

I gave Ike an update on the possible real estate plan tonight that you shared with me, including the congressional committee. I am available to serve on it as we discussed and ready to help formulate more thoughts about it when you are ready. Also ready to help with the Fraud plan.

On Tue, Apr 18, 2017 at 9:17 PM, David shulkin <Drshulkin@aol.com> wrote:

Sent from my iPhone

On Apr 18, 2017, at 7:10 AM, Marc Sherman <(b) (6) gmail.com> wrote:

> I totally agree. Thanks for taking the time. I will send the plan in Word when I get to into the office in a while. I was also thinking about a few other things that we should catch up on.
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We can- its a process- first we have to do a market survey to show OPM- we need our leadership to do this sooner and more aggressively

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AMERICAN OVERSIGHT

Agree - we are standing up a Committee and we need to message this effort - we are talking to the White House about this tommoroW

> 3. We didn't discuss all steps in my agenda on the crisis plan last night since we ran out of time. We should discuss the rest of the items to see if we can figure out which ones are valuable to implement and then discuss them so we can come to the best approach on each.

Ok- lets plan on another get together soon

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Dinner Discussion Agenda

Reputation on the line | 21 months | Ammunition *(see article highlights below)*

Crisis Management Discussion

1. System is in crisis – Engage crisis management program - URGENCY
2. Can't afford another DC | Almost guaranteed
3. Need Crisis plan – EXECUTE NOW
    a. Need to understand the immediate risks NOW
    b. ID trusted people in field | reassign | increase filed based reliable intelligence
        i. Wharton's Mack Center for administrator assessment
    c. NLC NOW - Use DC as a catalyst to show urgency and send message
    d. Make managers/administrators responsible |Report Card (back to HQ)
    e. ID problems now
        i. Outside quality / standards reviewers – report back to HQ with immediate action (Bruce can help to arrange – SEE OUTSIDE QUALITY REVIEW STANDARDS LIST BELOW)
        ii. Talk to medical staff in private
        iii. Fix problems immediately
        iv. Understaff | Procedural experience | shutdown & ID alternatives
        v. Reduce each facility to available skills and resources
    f. Curtail risks | Publicize new sheriff's in town | Reduce blame ammo (DC article sets the stage) | Partner with Tester etc to manage risk and get authority
    g. Plan progress within next week

Restructure Discussion

1. Telemedicine Exec Order | Opioid impact
2. Corruption of Supply Chain |Purchasing
    a. Expect significant deviation from expectations
    b. Need full assessment of existing system
    c. Revamp system to remove risks
    d. Examine P-Cards to curtail cost and quality issues
    e. Tie in Device Registry
    f. Tie in inventory system

Other Discussion Items

1. Real Estate (continuation of last week's | Congressional Commission
2. FW&A (Medicare system – participate in program demo
3. Cerner vs EPIC – Procurement issues
4. CIO

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OUTSIDE QUALITY REVIEW STANDARDS (first cut)

- Arrive unannounced and tour all areas of the hospital WITHOUT THE ADMINISTRATIVE STAFF so staff can speak freely of their concerns.
- Spot check for adequate supplies in every department
- Account for adequacy and quality of equipment in the ED, radiology, pathology, ICU, OR, LABS, cardiac cath lab and cardiac monitoring.
- Review medical personnel staffing and close any area of the hospital that would jeopardize patient care from understaffing.
- Suspend any low volume procedure that does not meet proficiency of care standards. For instance if the cath lab does not have the volume found safe by the American College of Cardiology.
- From the administrative staff request to see any personnel issues that are now under report and if those critical to patient care have been suspended from current patient care.
- Review all onsite and off-site storage units and inventory system operations and how recalled medical equipment has been accounted for.
- Review narcotics inventory and management system and reporting, Review all reported breaches in securing or prescribing addictive medication
- Review all patient and staff reported concerns regarding quality of care issues.

EXCERPTS FROM MARCH 12, 2017 ARTICLE

A downplayed risks at Chicago facility, watchdog says

By Drew Griffin and Curt Devine CNN Investigations
Updated 3:34 PM ET, Sun March 12, 2017

Story highlights

- Doctor alleged life-threatening delays in care and unnecessary heart procedures at VA hospital
- Watchdog agency disputes VA findings of no "specific danger to public health or safety"

*(CNN)*Six years after a whistleblower warned of poor care at a VA hospital near Chicago, a top government watchdog is warning that the Department of Veterans Affairs downplayed the risks.

The concerns were first raised in 2011 by Dr. Lisa Nee, a cardiologist at Edward Hines Jr. VA Hospital, just west of Chicago.

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Her claims: Veterans were being subjected to unnecessary coronary artery bypass surgeries. She also said that the hospital's echocardiogram laboratory had a one-year backlog and that many patients had died or suffered complications before their echocardiograms were reviewed.
She says her concerns were ignored and she left the VA in 2013. Nee became a whistleblower and took her case to the U.S. Office of Special Counsel, which protects government workers who report damaging information about the agencies where they work.
"I have absolutely no doubt patients died as a result of the care they did not get at the VA Hines facility," Nee told CNN from Chicago, where she now works as chief medical officer for a medical start-up. No VA investigation has made that determination.

The letter also described a "lack of accountability," stating that the VA's medical inspector identified repeated errors by one physician without taking any disciplinary action. The physician is still at Hines.

The Office of Special Counsel's letter says the VA took some corrective actions, but added that Nee had raised unresolved issues.

A Hines VA spokesperson said in a statement to CNN that the facility has hired additional cardiologists and responded to recommendations by the Inspector General by changing diagnostic and post-procedure review processes.
"Providing a safe environment and quality care for our Veterans is the top priority at the Hines VA Hospital," the statement said. "All Cardiology Peripheral Vascular procedures in 2016 were completed without adverse complications and with good outcomes. Hines VAH has implemented an ongoing Cardiology Quality Improvement Plan that includes validation of the accuracy of the interpretation and technical quality of echocardiography studies, and ensures that all echocardiography technicians have the opportunity for continuing education and training."

Recently sworn-in VA Secretary David Shulkin has vowed to improve patient access to quality VA health care. "I think that we have a system that is doing terrific things with very dedicated people, but we all know we have a lot of work to do and that's what I plan to do as secretary," Shulkin said in February.

Nee is not convinced, and is disappointed no one from the Trump administration or transition team has met with her regarding her allegations.
"You can't have a system that is supposed to take care of patients, and have a system that never takes account for its own mistakes," said Nee.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 1:17:00 AM
To: Marc Sherman [(b) (6) gmail.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Thanks

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(202) 758-(b) (6)

AMERICAN OVERSIGHT

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> Marc Sherman
> (202) 758-(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/18/2017 11:10:27 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; David shulkin [drshulkin@aol.com]; Bruce Moskowitz [(b) (6) mac.com]
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AMERICAN OVERSIGHT

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CC: David shulkin [drshulkin@aol.com]; (b) (6) mac.com; Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 11:27:06 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: Invitation - (from (b) (6) Intrepid Salute to Freedom Gala Info (Thurs May 25, 2017)

Lets discuss

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) cushwake.com>
> **Date:** April 19, 2017 at 11:39:54 AM EDT
> **To:** "David Shulkin (DRShulkin@aol.com)" <DRShulkin@aol.com>
> **Subject: Invitation - (from (b) (6) Intrepid Salute to Freedom Gala Info (Thurs May 25, 2017)**
>
> Good Afternoon Sec. Shulkin,
>
> Bruce invites you and your wife to join his table at the **Intrepid Salute to Freedom Gala,** held on **Thursday May 25th, 2017.**
>
> The event takes place in New York City, onboard the Intrepid Museum itself. Below are further details regarding this gala.
>
> **Kindly please RSVP directly to this email.**
>
> Thank you,
> (b) (6)

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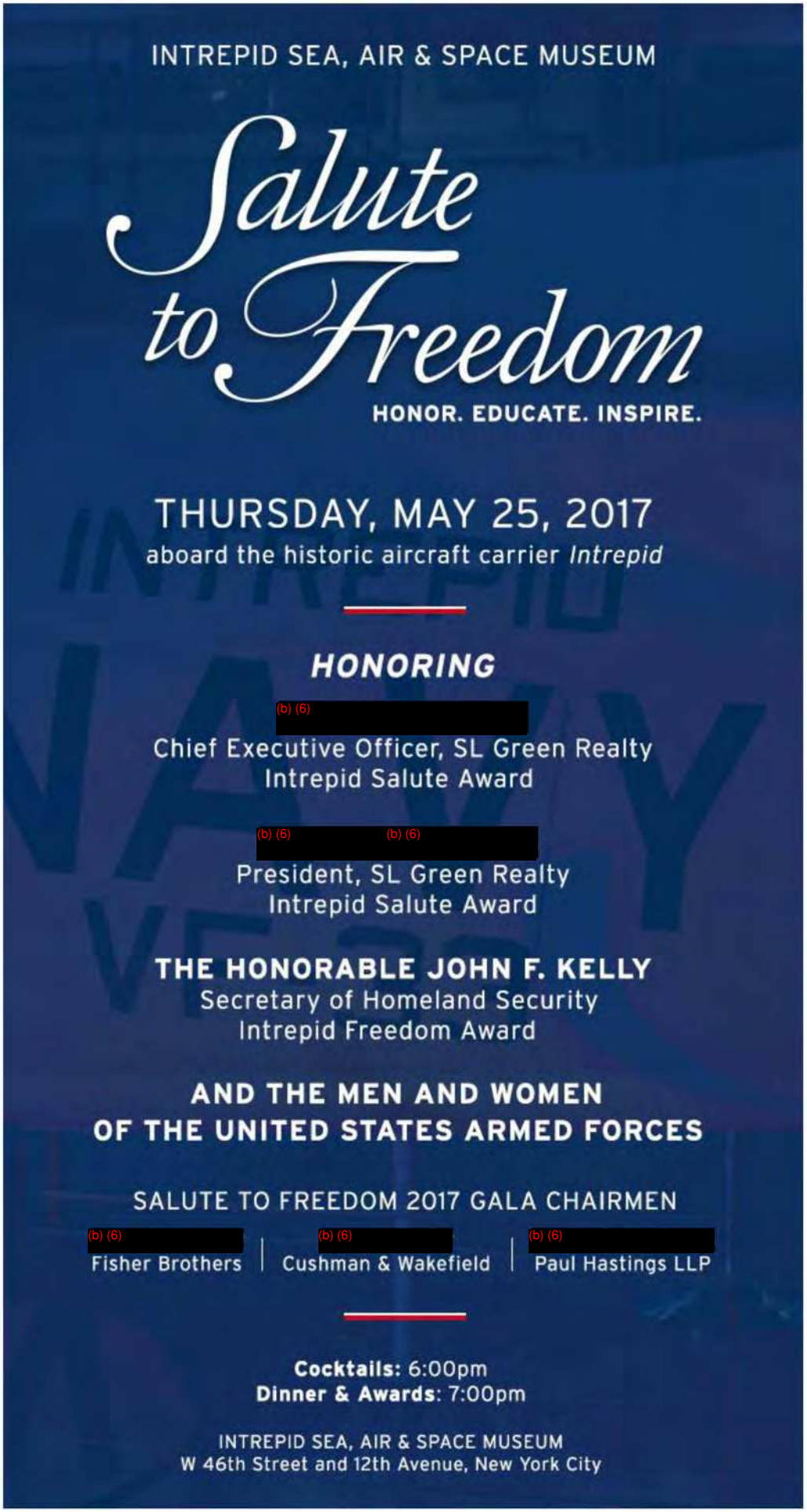

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The information contained in this communication is confidential, may be privileged and is intended for the exclusive use of the above named addressee(s). If you are not the intended recipient(s), you are expressly prohibited from copying, distributing, disseminating, or in any other way using any information contained within this communication. If you have received this communication in error please contact the sender by telephone or by response via mail.

We have taken precautions to minimize the risk of transmitting software viruses, but we advise you to carry out your own virus checks on any attachment to this message. We cannot accept liability for any loss or damage caused by software viruses.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/24/2017 12:43:15 AM
To: IP [(b) (6) frenchangel59.com]
CC: David shulkin [drshulkin@aol.com]
Subject: Re: Thank you

Thanks Ike- a very important meeting with all the key areas needed to be discussed. David and I will see if there is anything else to add to the agenda, but looks really good thus far.

Sent from my iPhone

On Apr 23, 2017, at 5:26 PM, IP <(b) (6) frenchangel59.com> wrote:

From: IP [mailto:(b) (6) frenchangel59.com]
Sent: Sunday, April 23, 2017 5:25 PM
To: (b) (6) who.eop.gov
Cc: (b) (6) @who.eop.gov
Subject: Thank you

Jared,

Thank you for getting back to me and for committing the time to join us for dinner on Wednesday, April 26th. Especially thank you for the generous invitation to dine at your house. We expect between 10 to 13 people in total. The final number will depend on whether Senator Isakson and Representative Roe accept our invitation. I totally understand if that is too large a group to host and hope you will be honest about your willingness and ability now that you know how big it is.

Best,
Ike

==========

DRAFT Agenda Items to be defined around finalized attendee list. Attendee list and agenda items subject to change.

<image001.jpg>

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/23/2017 9:25:49 PM
To: Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
Subject: FW: Thank you

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Possible Attendee	Agenda item to be considered
DOD	Cooperation between DOD and VA on mental and physical health tracking to prevent medical and mental health issues
Need to Determine - [Identified Physician Residency Link]	Medical residency slots that are linked to Veteran Care (almost every congressional meeting is focused on lack of medical hiring at the VA and with the huge physician shortage in the private sector there is no solution).
1. White House 2. DOD 3. Also a good discussion to have with Senator Isakson and Representative Roe	1. EMR, Cerner v. Epic, Procurement, one time legislative exemption. 2. The impediments of the procurement rules and the risks to life and saving lives.
1. White House 2. Congress	Inventory management systems, device registry and supply chain - also a procurement issue
White House	Telemedicine Executive Order
Congressmen	Choice 2.0
1. DOD 2. Identified Physician Residency Link	PTSD
1. White House 2. Congress	1. Competitive medical hiring flexibility. 2. Accountability

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/19/2017 10:49:52 PM
To: Bruce Moskowitz [redacted]mac.com]
CC: David Shulkin [drshulkin@aol.com]; [redacted] [redacted]va.gov]
Subject: phone numbers and email?

Good evening Dr. Moskowitz,

By chance would you have an email or phone number for the following - we are working to get these schedule and notice their resumes do not have any contact information,

Dr. [redacted] - Yale
Dr. [redacted] - Yale University

thanks,
[redacted]

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/21/2017 1:08:09 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Meeting at Whitehouse

Were looking into the presidents flexability

Sent from my iPhone

On Apr 21, 2017, at 8:20 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> So far only (b) (6) responded to positive for following week
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> Begin forwarded message:
>
> **From:** "(b) (6) (b) (6) <(b) (6) ccf.org>
> **Date:** April 21, 2017 at 8:18:52 AM EDT
> **To:** Bruce Moskowitz <(b) (6) mac.com>
> **Subject: RE: Meeting at Whitehouse**
>
> Unfortunately I would be unable to attend either day because of commitments here at Cleveland Clinic I cannot move.
>
> (b) (6)
>
> (b) (6) MD
> CEO and President
>
> 9500 Euclid Avenue, NA4
> Cleveland, OH 44195
> Phone: (216) 444-(b) (6)
> Fax: (216) 444-(b) (6)
> (b) (6) @ccf.org
>
> -----Original Message-----
> From: Bruce Moskowitz [mailto:(b) (6) mac.com]
> Sent: Thursday, April 20, 2017 6:42 PM
> To: (b) (6) partners.org; (b) (6) (b) (6) <(b) (6) ccf.org>; (b) (6) <(b) (6) jhmi.edu>; (b) (6) M.D. <(b) (6) mayo.edu>; (b) (6) (b) (6) <(b) (6) mayo.edu>; (b) (6) (b) (6) kp.org
> Subject: Meeting at Whitehouse
>
> What is chance of feet in everyone to be at a bill signing and half day meeting with President and we would try to get Tim Price there either next Thursday or following Tuesday

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Sent from my iPhone

==========

Please consider the environment before printing this e-mail

Cleveland Clinic is ranked as one of the top hospitals in America by U.S.News & World Report (2015).
Visit us online at http://www.clevelandclinic.org for a complete listing of our services, staff and locations.

Confidentiality Note: This message is intended for use only by the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please contact the sender immediately and destroy the material in its entirety, whether electronic or hard copy.

Thank you.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/21/2017 12:20:31 PM
To: David shulkin [drshulkin@aol.com]
Subject: Fwd: Meeting at Whitehouse

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Sent from my iPad
Bruce Moskowitz M.D.

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(b) (6)

(b) (6) MD
CEO and President

9500 Euclid Avenue, NA4
Cleveland, OH 44195
Phone: (216) 444-(b) (6)
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(2015).
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AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/20/2017 2:43:46 AM
To: (b) (6) gmail.com
Subject: amazon
Attachments: amazon.docx

Please print

AMERICAN OVERSIGHT

amazon.com

I've been reminding people that it's Day 1 for a couple of decades. I work in an Amazon building named Day 1, and when I moved buildings, I took the name with me.

"Day 2 is stasis. Followed by irrelevance. Followed by excruciating, painful decline. Followed by death. And *that* is why it is *always* Day 1."

To be sure, this kind of decline would happen in extreme slow motion. An established company might harvest Day 2 for decades, but the final result would still come.

I'm interested in the question, how do you fend off Day 2? How do you keep the vitality of Day 1, even inside a large organization?

I don't know the whole answer, but I may know bits of it. Here's are some essentials for Day 1 defense: customer obsession, and high-velocity decision making.

There are many ways to center a business. You can be competitor focused, you can be product focused, you can be technology focused, you can be business model focused, and there are more. But in my view, obsessive customer focus is by far the most protective of Day 1 vitality.

Why? There are many advantages to a customer-centric approach, but here's the big one: customers are *always* beautifully, wonderfully dissatisfied, even when they report being happy and business is great. Even when they don't yet know it, customers want something better, and your desire to delight customers will drive you to invent on their behalf.

Staying in Day 1 requires you to experiment patiently, accept failures, plant seeds, protect saplings, and double down when you see customer delight. A customer-obsessed culture best creates the conditions where all of that can happen.

Day 2 companies make high-*quality* decisions, but they make high-quality decisions *slowly*. To keep the energy and dynamism of Day 1, you have to somehow make high-quality, *high-velocity* decisions. Easy for start-ups and very challenging for large organizations. The senior team at Amazon is determined to keep our decision-making velocity high. Speed matters in business – plus a high-velocity decision making environment is more fun too. We don't know all the answers, but here are some thoughts.

Most decisions should probably be made with somewhere around 70% of the information you wish you had. If you wait for 90%, in most cases, you're probably being slow. Plus, either way, you need to be good at quickly recognizing and correcting bad decisions. If you're good at course correcting, being wrong may be less costly than you think, whereas being slow is going to be expensive for sure.

Second, use the phrase "disagree and commit." This phrase will save a lot of time. If you have conviction on a particular direction even though there's no consensus, it's helpful to say, "Look, I know we disagree on this but will you gamble with me on it? Disagree and commit

I disagree and commit all the time. We recently greenlit a particular Amazon Studios original. I told the team my view: debatable whether it would be interesting enough, complicated to produce, the business terms aren't that good, and we have lots of other opportunities. They had a completely different opinion and wanted to go ahead. I wrote back right away with "I disagree and commit and hope it becomes the most watched thing we've ever

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made." Consider how much slower this decision cycle would have been if the team had actually had to *convince* me rather than simply get my commitment.

Note what this example is not: it's not me thinking to myself "well, these guys are wrong and missing the point, but this isn't worth me chasing." It's a genuine disagreement of opinion, a candid expression of my view, a chance for the team to weigh my view, and a quick, sincere commitment to go their way. And given that this team has already brought home 11 Emmys, 6 Golden Globes, and 3 Oscars, I'm just glad they let me in the room at all!

Third, recognize true *misalignment* issues early and escalate them *immediately*. Sometimes teams have different objectives and fundamentally different views. They are not aligned. No amount of discussion, no number of meetings will resolve that deep misalignment. Without escalation, the default dispute resolution mechanism for this scenario is exhaustion.

(b) (6)



Founder and Chief Executive Officer
Amazon.com, Inc.

1997LETTERTOSHAREHOLDERS
(Reprinted from the 1997 Annual Report)

Amazon.com, Inc.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 10:24:33 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Train on Sunday

With (b) (6) Dad im not sure yet

Sent from my iPhone

> On Apr 19, 2017, at 6:13 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Let me know what and if you are taking the train on Sunday
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/19/2017 10:13:56 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Train on Sunday

Let me know what and if you are taking the train on Sunday

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/16/2017 1:24:12 PM
To: Marc Sherman [(b) (6) gmail.com]
CC: Bruce Moskowitz [(b) (6) mac.com]; L Perl [(b) (6) gmail.com]; (b) (6) hotmail.com; IP [(b) (6) frenchangel59.com]
Subject: Re: From yesterday's discussion

This is a great start- Lets us work on a checklist like this and get back to you

Sent from my iPhone

On Apr 16, 2017, at 8:35 AM, Marc Sherman <(b) (6) gmail.com> wrote:

> Totally agree. Great ideas. From my non-medical perspective, couldn't agree more with the "tour...WITHOUT THE ADMINISTRATIVE STAFF" approach.
>
> Marc Sherman
> (202) 758-(b) (6)
>
> On Apr 16, 2017 8:12 AM, "Bruce Moskowitz" <(b) (6) mac.com> wrote:
> If we adapt the fix it before it breaks slogan then the 18 regional managers need to be held accountable for the following (probably many if not all are in place now):
>
> That they arrived unannounced and proceeded to tour all areas of the hospital WITHOUT THE ADMINISTRATIVE STAFF so staff can speak freely of their concerns.
>
> Personally spot checked for adequate supplies in every department
>
> Account for the radiology, lab, pathology , intensive care units and surgical suites and cardiac monitoring units have updated equipment to meet the new standards of care.
>
> Review medical personnel staffing and close any area of the hospital that would jeopardize patient care from understaffing.
>
> Suspend any low volume procedure that does not meet proficiency of care standards. For instance if the cath lab does not have the volume found safe by the American College of Cardiology.
>
> From the administrative staff request to see any personnel issues that are now under report and if those critical to patient care have been suspended from current patient care.
>
> Request to see all onsite and off site storage units and how recalled medical equipment has been accounted for.
>
> Request to see any reported breach in securing or prescribing addictive medication
>
> Request to see patient or staff reported concerns regarding quality of care issues.

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Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/16/2017 12:35:39 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: L Perl [(b) (6) gmail.com]; David shulkin [drshulkin@aol.com]; (b) (6) hotmail.com; IP [(b) (6) frenchangel59.com]
Subject: Re: From yesterday's discussion

Totally agree. Great ideas. From my non-medical perspective, couldn't agree more with the "tour...WITHOUT THE ADMINISTRATIVE STAFF" approach.

Marc Sherman
(202) 758-(b) (6)

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That they arrived unannounced and proceeded to tour all areas of the hospital WITHOUT THE ADMINISTRATIVE STAFF so staff can speak freely of their concerns.

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Review medical personnel staffing and close any area of the hospital that would jeopardize patient care from understaffing.

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Request to see patient or staff reported concerns regarding quality of care issues.

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/16/2017 8:17:12 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Questions about DC VAMC

Lets discuss

Sent from my iPhone

Begin forwarded message:

> **From:** "Slack, Donovan" <dslack@usatoday.com>
> **Date:** April 16, 2017 at 4:08:08 PM EDT
> **To:** David Shulkin <Drshulkin@aol.com>
> **Subject: Fwd: Questions about DC VAMC**
>
> I wanted to tell you personally what I am up to here with these questions below. I am turning my sites on those layers of bureaucracy between u, dr Alleigh and the field. I hope and pray you see it as a gift to drive internal change :)
> D
>
> ---
> Donovan Slack
> White House and Veterans Affairs Correspondent
> USA TODAY
> dslack@usatoday.com
> (703) 854-8926 Office
> (202) 415-9493 Cell
>
> Begin forwarded message:
>
> > **From:** "Slack, Donovan" <dslack@usatoday.com>
> > **Date:** April 14, 2017 at 4:34:35 PM EDT
> > **To:** "(b) (6) ((b) (6) va.gov)" <(b) (6) va.gov>, "Hutton, James (James.Hutton@va.gov)" <James.Hutton@va.gov>
> > **Subject: Questions about DC VAMC**
> >
> > (b) (6) and James,
> > I have some questions below about the DC VAMC and what led up to this week's crisis. Can I speak with someone about this? My deadline is end of business Monday.
> > Thanks,
> > Donovan
> >
> > -According to the IG report, the VHA Procurement and Logistics Office, policy assistance and quality, found no VA approved inventory management system in place and infection control issues in multiple clinical supply areas at DC VAMC Jan. 24-26, 2017.
> >
> > -The Deputy Undersecretary for Health for Operations and Management, Steven W. Young, sent a memo on March 21, 2017, directing the VISN 5 Director and the medical center director to provide a corrective action plan.

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1) Why did Mr. Young wait two months to ask for this?
2) What prompted him to ask for it?
3) According to the timeline (see below), the VISN took the lead in addressing issues at VAMC and repeatedly suggested they were being remediated, so why was the medical center director relieved of duty pending investigation and not the VISN officials?
4) Is VISN director Joseph A. Williams, Jr., being held accountable and how? If not, why not?
5) He was previously assistant deputy undersecretary for health for operations and management. Why the demotion and when?
6) Who is the VISN deputy chief medical officer that visited DC VAMC on March 22, March 30 and March 31? (And who was asked to help get vascular patches but didn't) Is he or she being held accountable? How and why or why not?
7) Why were the deficiencies noted by the IG missed or not remedied by all the various VISN officials?
7) Did the various VACO officials who received VISN reports have confidence in them? Why or why not and what did they do? (Deputy Undersecretary for Health for Operations and Management, Steven W. Young; Thomas Lynch, Assistant Deputy Under Secretary for Health for Clinical Operations at Department of Veterans Affairs; Tammy Czarnecki, Assistant Deputy USH for Administrative Operations; (b) (6) Director of the National Center for Patient Safety; Ricky Lemmon, Acting Chief Procurement and Logistics Officer; Sharon Ridley, executive director network support)
8) Did the Deputy Undersecretary for Health for Operations and Management, Steven W. Young, brief the (acting) Undersecretary for Health Dr. Poonam Aleigh? If so, when and what did she do about it? If not, why not?
9) Did Dr. Aleigh brief Secretary Shulkin? If not, why not? If so, what did he do about it and when?
10) How will he prevent this from happening again?

TIMELINE:
-On March 21, 2017, VISN 5 submits an "issue brief" on the situation that says a "comprehensive action plan" has been created and is being executed. VISN 5 supply chain office is migrating to new inventory management system, staffing within DC supply chain was 45% vacant and positions were posted, says the VISN 5 Supply Chain Office will "continue to review all facets of the supply chain, and provide guidance and assistance in rectifying any deficiencies that exist."
These people were part of the communication on the brief: Raymond Chung, MD, Chief Medical Officer, VISN5; (b) (6) Quality Management Officer, VISN 5; (b) (6) , deputy network director, VISN 5; and (b) (6) , patient safety officer VISN5.
These people received the brief: Deputy Undersecretary for Health for Operations and Management, Steven W. Young; Thomas Lynch, Assistant Deputy Under Secretary for Health for Clinical Operations at Department of Veterans Affairs; Tammy Czarnecki, Assistant Deputy USH for Administrative Operations; (b) (6) Director of the National Center for Patient Safety; Ricky Lemmon, Acting Chief Procurement and Logistics Officer; Sharon Ridley, executive director network support.

-On March 22, VISN 5's deputy chief medical officer and patient safety officer conducted a "focused review" at the DC VAMC and found …"no issues were identified that posed an immediate risk to patient safety, however, several policy and practice inconsistencies and Environment of Care concerns were validated that could potentially impact patient safety," but said immediate risks were corrected at time of review

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-On March 30-31, VISN 5 deputy chief medical officer again visited the DC VAMC to "check the status of critical supplies that if not present , could adversely affect patient care and put patients at risk"
-Over the April 1-2 weekend, the "Tiger team" working at the DC VAMC included the VISN 5 chief logistics officer, VISN 5 deputy chief logistics officer (and eight logistics employees from Martinsburg VAMC)

-Per the IG, on March 30, facility ran out of dialyzer bloodlines, and other equipment deficiencies on April 4, 5 and 11 (OR runs out of vascular patches despite asking VISN 5 deputy chief medical officer two weeks earlier)

###

_____

Donovan Slack
White House and Veterans Affairs Correspondent
USA TODAY
(703) 854-8926 office
(202) 415-9493 cell

AMERICAN OVERSIGHT

Message

From: [(b) (6)frenchangel59.com]
Sent: 4/18/2017 12:01:59 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: WSJ - Trump's Promise to Veterans

Lets discuss before I answer. Thank you

https://www.wsj.com/articles/trumps-promise-to-veterans-1492123100

Trump's Promise to Veterans

Corruption at the VA isn't punished, while the Pentagon claws back signing bonuses.



VA headquarters in Washington, D.C. *PHOTO: ASSOCIATED PRESS*

By

Rebecca Burgess

April 13, 2017 6:38 p.m. ET

71 COMMENTS

Donald Trump pitched himself as a friend to the American military, and to veterans in particular. His campaign pledged to fix the Department of Veterans Affairs "by firing the

AMERICAN OVERSIGHT

corrupt and incompetent VA executives who let our veterans down." Since taking office, however, President Trump hasn't defined what, if anything, his administration will do to make good on that promise. Here are a couple of obvious wrongs he can easily make right.

In 2015, a pair of senior VA officials were accused of defrauding the department to the tune of $400,000. Diana Rubens and Kimberly Graves, the directors of two regional VA offices, had allegedly manipulated the department's hiring and transfer systems for personal financial gain. Ms. Rubens was accused of pressuring a subordinate to leave the VA's Philadelphia office so she could take the job herself, move from Washington, and collect a $288,000 relocation payout. Similarly, Ms. Graves received more than $129,000 by engineering a move from Philadelphia to St. Paul, Minn.

Allison Hickey resigned in October 2015 as the VA undersecretary for benefits amid investigations into her role in the scheme. Ms. Rubens and Ms. Graves were called to appear before the House Veterans Affairs Committee that November, but they refused to testify, invoking their Fifth Amendment right against self-incrimination. Instead of being fired, the pair were demoted. Due to a VA "paperwork mistake," however, the demotion had to be rescinded in December 2015 and reissued.

— ADVERTISEMENT —

Then the two got a reprieve from the Merit Systems Protection Board, the quasijudicial agency whose mission, in part, is to review the disciplining of federal employees. The MSPB is the successor of the U.S. Civil Service Commission, originally set up to protect federal workers from partisan recrimination.

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In early 2016 the MSPB fully reversed the punishments of Ms. Rubens and Ms. Graves. Furthermore, the VA did not to try to recover the taxpayer funds that the pair had collected for relocating. It seems that since "senior officials" approved the $400,000, it would have been somehow improper to ask for the money back.

Yet the Los Angeles Times revealed in October 2016 that the Defense Department had been forcing National Guard veterans to repay re-enlistment bonuses—sometimes up to $20,000—they had received during the mid-2000s. The Pentagon said the bonuses were improperly awarded. Nearly 10,000 soldiers, the Times reports, have faced everything from retroactive interest to wage garnishment to tax liens. Debt collectors and tanked credit scores, the result of the retroactive action, will haunt many of them for the foreseeable future.

Unlike the senior VA officials, these soldiers weren't accused of conspiring to game the system. Rather, each signed a service contract and happily took the bonus that the military, under pressure to make up enlistment shortfalls, was eagerly offering. Many consequently deployed for multiple tours. What a way to thank them for their service.

Auditors later determined that the incentive program of the California Army National Guard had been operated like a slush fund, with as much as $100 million misspent. The program's onetime leader, former Master Sgt. Toni Jaffe, was sentenced in May 2012 to 30 months in prison after pleading guilty to filing $15.2 million in false claims. Three other officers were put on probation and forced to pay restitution.

Yet, for some reason, the Pentagon decided to claw back money from the veterans who had received the bonuses. Congress, it turns out, knew about the situation—or at least the California delegation did. When the story hit the press, then-Defense Secretary Ash Carter ordered a halt to the bonus hunting. But the order focused mostly on reviewing and streamlining the process. "This process has dragged on too long, for too many service members," Mr. Carter's statement said. "Too many cases have languished without action." Little was said about the underlying injustice of the matter.

Process is certainly important. As Alexander Pope mused: "For Forms of Government let fools contest; Whate'er is best administer'd is best." But Alexander Hamilton countered the point in Federalist 68. "The true test of a good government," he wrote, "is its aptitude and tendency to produce a good administration."

The rules at the Defense Department and the VA must apply to senior officials and enlisted soldiers alike. Without consistency, even the best process fails from the standpoint of justice.

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Exhibit A: the VA, where employees are rewarded because they technically followed a process. Exhibit B: the Pentagon, which could not protect even itself with its own processes. If Mr. Trump wants to do right by veterans and the military, he could begin by insisting on consistency.

Ms. Burgess manages the Program on American Citizenship at the American Enterprise Institute.
Appeared in the Apr. 14, 2017, print edition as 'Trump's Promise to Veterans.'

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]hotmail.com]
Sent: 4/21/2017 10:29:44 PM
To: David [drshulkin@aol.com]
Subject: Fwd: The Alaigh's Celebration of Friendship

We cant go, should i rsvp

Sent from my iPhone

Begin forwarded message:

From: [redacted] and Poonam Alaigh <info@mailva.evite.com>
Date: April 21, 2017 at 5:58:19 PM EDT
To: David Shulkin <[redacted]hotmail.com>
Subject: The Alaigh's Celebration of Friendship
Reply-To: Evite <[redacted]hotmail.com>

evite

You're Invited

The Alaigh's Celebration of Friendship

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(b) (6) **and Poonam Alaigh** sent you an invitation.

RSVP Now! View Invitation

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Evite respects your privacy. For more information, please review our privacy policy.
Add info@mailva.evite.com to your address book to ensure that you receive Evite emails in your inbox.
Have a question? Visit Evite's support page.
Don't want to receive any Evite emails from this person? Block this host.

This email was sent to (b) (6) hotmail.com

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Please use this mark only to refer to our services. Other names may be trademarks of their respective owners.

evite™

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 11:05:39 AM
To: (b) (6) [(b) (6) va.gov]
CC: (b) (6) hotmail.com; (b) (6) [(b) (6) va.gov]
Subject: Re: [EXTERNAL] Hepatitis paper

Thank you

Sent from my iPhone

On Apr 18, 2017, at 1:06 AM, (b) (6) (b) (6) va.gov> wrote:

Hi Dr. Shulkin and Dr. Alaigh,

Please find attached the data on the number of veterans we have treated and our SVR (cure) rates among those we have treated since the availability of the oral DAAs.

In the attached spreadsheet (HCV VA data sources.xls), please find three tabs:

Tab 1 shows the daily cumulative total of veterans starting on oral HCV DAAs. We started prescribing in VA in Jan 2014, though they were FDA approved in Nov 2013. This summary graph is also posted and is available at the first link listed below.
Number of veterans treated since DAA availability:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/default.aspx

Tab 2 of the spreadsheet shows the number of veterans *awaiting treatment* at periodic intervals beginning with FY14 (DAAs introduced in VA in Q2 FY14). This is data captured from the HCV Clinical Case Registry. Those in the paper reflect the end of March (Q2 FY17).
This data is also posted and is available at the link listed below:
Numbers *awaiting* treatment – this is updated quarterly.
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Viremic/viremic-fib4.aspx

Tab 3 of the spreadsheet shows the raw data that relates to the "Cascade of HCV Care" (figure 3) with a brief sentence about the methods used to calculate each "step". For more detailed methods, refer to the attached Maier et al paper. We used the same methods for the current cascade as we did in this previously published paper. Note that the cascade numbers represent all HCV patients in care *ever treated* (even with earlier non-DAA regimens before 2014) which is why the SVR percentages in the cascade graph are lower than what the SVR rates are with all oral DAA regimens (shown in link below – which represent SVR rates of only oral DAA regimens from 2014 and beyond).
SVR (cure) rates with *all oral DAA regimens* are posted here and updated every two weeks:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Antivirals%20Tests/HCV_Direct_Acting_Antivirals.aspx
From table at above link, SVR rate calculated as SVR12/(NoSVR+SVR12) = 94.98%; Published data on SVR rates available in the attached article.

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HCV testing rates are updated and posted quarterly, (those in the paper reflect the end of March, Q2 FY17) :
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvbirthcohort/hcv_cohorts_fiscal_year/default.aspx

Please let me know if you have any additional questions about the data or would like to have copies of any of the other references in the paper.

Best,
(b)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Sunday, April 16, 2017 9:59 AM
To: (b) (6) (b) (6) (b) (6) hotmail.com
Subject: [EXTERNAL] Hepatitis paper

(b) and (b) (6) and Poonam- you did a spectacular job writing this up and its a remarkable story that has occurred at VA.
I think this is exactly the type of manuscript that is needed so others can benefit from your experience and also
that VA can be appropriately recognized for its' leadership in this area.

I surprisingly made very few edits or corrections in the paper which is a real tribute to you all.
Please take a look and make sure you agree with these few changes.

The one request I would make is to be an author on this paper I feel it is important that I review the data that you used to put the statistics in the paper about how many veterans we treated and our success rates.
Do you have any reports or data that you could share so Dr. Alaigh and I can review before we put our names on the manuscript?

I don't know if Dr. Alaigh has had time yet to review.

The annals seems appropriate or if not a hepatology journal surely would be interested.

Thanks so much for your leadership here

David Shulkin MD

<HCV VA data sources.xlsx>

<Maier_AJPH201512546R3_2nd_ProofCXs.pdf>

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) va.gov]
Sent: 4/18/2017 5:06:43 AM
To: David Shulkin [drshulkin@aol.com]; (b) (6) hotmail.com
CC: (b) (6) [(b) (6) va.gov]
Subject: RE: [EXTERNAL] Hepatitis paper
Attachments: HCV VA data sources.xlsx; Maier_AJPH201512546R3_2nd_ProofCXs.pdf

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SVR (cure) rates with *all oral DAA regimens* are posted here and updated every two weeks:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Antivirals%20Tests/HCV_Direct_Acting_Antivirals.aspx
From table at above link, SVR rate calculated as SVR12/(NoSVR+SVR12) = 94.98%; Published data on SVR rates available in the attached article.

HCV testing rates are updated and posted quarterly, (those in the paper reflect the end of March, Q2 FY17) :
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvbirthcohort/hcv_cohorts_fiscal_year/default.aspx

Please let me know if you have any additional questions about the data or would like to have copies of any of the other references in the paper.

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(b)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Sunday, April 16, 2017 9:59 AM
To: (b) (6) (b) (6) (b) (6) hotmail.com
Subject: [EXTERNAL] Hepatitis paper

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David Shulkin MD

AMERICAN OVERSIGHT

Cascade of Care for Hepatitis C Virus Infection Within the US Veterans Health Administration

Marissa M. Maier, MD, David B. Ross, MD, PhD, MBI, Maggie Chartier, PsyD, MPH, Pamela S. Belperio, PharmD, and Lisa I. Backus, MD, PhD

Objectives. We measured the quality of HCV care using a cascade of HCV care model.

Methods. We estimated the number of patients diagnosed with chronic HCV, linked to HCV care, treated with HCV antivirals, and having achieved a sustained virologic response (SVR) in the electronic medical record data from the Veterans Health Administration's Corporate Data Warehouse and the HCV Clinical Case Registry in 2013.

Results. Of the estimated 233 898 patients with chronic HCV, 77% (181 168) were diagnosed, 69% (160 794) were linked to HCV care, 17% (39 388) were treated with HCV antivirals, and 7% (15 983) had achieved SVR.

Conclusions. This Cascade of HCV Care provides a clinically relevant model to measure the quality of HCV care within a health care system and to compare HCV care across health systems. (*Am J Public Health*. Published online ahead of print November 12, 2015: e1–e6. doi:10.2105/AJPH.2015.302927)

Hepatitis C virus infection is the most common blood-borne infection in the United States. An estimated 2.7 to 3.9 million Americans are chronically infected, representing 1.0% to 1.5% of the US population.[1,2] The Veterans Health Administration (VHA) is the single largest provider of HCV care in the United States. The burden of chronic HCV is known to be higher among patients seen in the VHA than among the general population.[3]

Prior to 2014, HCV antiviral therapies required long treatment durations, had numerous treatment-limiting side effects, and resulted in sustained virologic response (SVR) or cure rates of approximately 50% overall; cure rates were even lower among those with genotype 1 infection,[4,5] the most common genotype in the United States. New direct-acting antiviral agents require shorter durations of therapy, have favorable side effect profiles, and yield cure rates of greater than 90% in clinical trials, even among genotype 1–infected patients.[6,7] Curing chronic HCV is associated with reduced all-cause mortality.[8–10]

With widespread use of more efficacious treatment regimens, it is helpful to use a population health approach to assess a health care system's ability to identify individuals with chronic HCV, link them to care, provide antiviral treatment, and achieve clinical cure. Doing so allows for identification of gaps in care and of foci for improvement. Yehia et al. proposed a 7-step cascade of care methodology that estimated that among individuals in the United States with chronic HCV, 16% had received antiviral therapy and 9% had achieved SVR.[11]

The cascade proposed by Yehia et al. may be limited in its applicability to large health care systems. For example, insurance status was used as a marker of access to outpatient care, which may not be applicable for a health care system trying to assess performance across the Cascade of Care among enrolled patients who, by definition, have health insurance. In addition, liver biopsy was included in their model, which in many cases may no longer be indicated. Finally, because their model concentrated on the entire US population, national seroprevalence surveys and patient self-reported survey data were used, which is not routinely available in a health care system.

We sought to create a cascade of HCV care that captured the current state of HCV care using steps applicable to a large health care system and that could be calculated with data generally available from an electronic medical record. We included an assessment of linkage to HCV-specific care because it is a more stringent measure than access to insurance or general medical care. We did not include patient awareness of infection, access to care, or liver biopsy as steps in our cascade. We developed and applied our cascade of HCV care in the VHA health care system.

METHODS

To create our cascade of HCV care, we determined the following:

1. number of patients with chronic HCV,
2. number of patients diagnosed with chronic HCV,
3. number of patients linked to HCV care,
4. number of patients treated with HCV antivirals, and
5. number of patients with an SVR.

For the first 2 steps, we used the VHA's Corporate Data Warehouse, a national database that captures birth dates, gender, race, ethnicity, health care encounters, and laboratory tests from October 1, 1999, onward for patients who received VHA care. The analysis included all patients in VHA care in 2013, where "in care" was defined as having at least 1 VHA outpatient visit (including telehealth) in 2013. We required only 1 outpatient visit in 2013 to capture as broad a population as possible while still ensuring that the patients were using VHA health care to some extent. We identified all HCV antibody, viral load, and genotype tests that had been obtained between October 1, 1999, and December 31, 2013, for patients in care in 2013. We considered individual test results "informative" if the result could be categorized as negative or positive for antibody tests, detectable or undetectable for viral load tests, and detectable for genotype tests if a recognized HCV genotype was reported. For each patient in care in 2013, we determined if the patient ever had positive or negative antibody tests, and detectable or undetectable HCV RNA testing from all identified

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tests. We considered patients with a positive enzyme immunoassay HCV antibody test result who had a subsequent negative recombinant immunoblot assay test result to have negative antibody testing. For this analysis, we accessed Corporate Data Warehouse data on January 15, 2014.

Number of Patients With Chronic HCV

The estimated total number of patients with chronic HCV in the population receiving VHA health care in 2013 is the sum of 3 subgroups: (1) those already identified with chronic HCV, (2) estimated additional cases from the projected prevalence among HCV antibody-positive patients who had not received RNA testing, and (3) estimated additional cases from the projected prevalence among the untested population.

Patients already identified with chronic HCV. Patients were considered to have chronic HCV if they ever had positive RNA-based testing (a detectable viral load or genotype).

Estimated additional cases from the projected prevalence among HCV antibody-positive patients who had not received RNA testing. We applied the observed prevalence of chronic HCV among HCV antibody-positive patients who had received RNA testing to the population that was HCV antibody positive but had not received RNA testing to estimate the prevalence of HCV in the latter population.

Estimated additional cases from the projected prevalence among the untested population. To project the prevalence of HCV among untested individuals (i.e., individuals without any HCV antibody, viral load, or genotype tests), we first determined chronic HCV incident diagnosis rates per year of testing for those in care in 2013 (i.e., the number of people with their first detectable HCV RNA test result in the year divided by the total number of people with informative HCV testing in the year). Since chronic HCV prevalence is known to vary by gender, race/ethnicity, and birth cohort (born before 1945, born 1945–1965, and born after 1965),[12,13] we determined incident diagnosis rates separately among these demographic subgroups.

In addition, since incident diagnosis rates in the VHA are decreasing over time as more people undergo HCV testing, we approximated the estimated prevalence rate for the untested population as the incident diagnosis rate in 2013 multiplied by the ratio of the 2013:2012 rates.[12] For those subgroups for which the incident diagnosis rate in 2013 was actually higher than the rate in 2012, we used the 2013 rate as the estimated prevalence rate for the untested population. We calculated estimates of the projected prevalence of chronic HCV in the untested population by applying the projected prevalence rate to the people in the untested population. For example, among non-Hispanic White men born from 1945 to 1965 who were in care in 2013, 72 723 had their first informative HCV testing in 2012, of whom 3686 had detectable HCV RNA, for an incident diagnosis rate of 5.07; 77 083 had their first informative HCV testing in 2013, of whom 3304 had detectable HCV RNA, for an incident diagnosis rate of 4.29. Thus, the projected prevalence rate among those untested in this demographic cohort is the ratio of the 2013:2012 rates multiplied by the rate in 2013 ($[4.29/5.07] \times 4.29 = 3.62$). Applying the projected prevalence rate of 3.62 to the 567 756 non-Hispanic White men born between 1945 and 1965 in care in 2013 and untested for HCV yields 20 553 additional cases of chronic HCV that would be found with complete testing of this demographic cohort.

Number of Patients Diagnosed With Chronic HCV

The number of patients in care in 2013 diagnosed with chronic HCV included those patients who had ever had a detectable viral load or genotype.

Number of Patients Linked to HCV Care

The VHA maintains a registry of HCV patients known as the HCV Clinical Case Registry, which was originally designed in part to ensure that patients with chronic HCV were linked to HCV care.[14] The registry software identifies patients as potentially having HCV on the basis of *International Classification of Diseases, Ninth Revision* (*ICD-9*)[15] codes or laboratory results and adds such patients to the list of "pending" patients. HCV Clinical Case Registry coordinators at each facility review the lists of pending patients to confirm the diagnosis of HCV. The HCV Clinical Case Registry also extracts information from the VHA electronic medical record, which includes laboratory results, pharmacy information, and *ICD-9* diagnosis codes from inpatient hospitalizations, outpatient visits, and problem lists of HCV-infected patients seen at all VHA medical facilities. HCV Clinical Case Registry data for this analysis was available through December 31, 2013.

We considered a patient with an outpatient visit in 2013 to be linked to HCV care if the patient was entered into the HCV Clinical Case Registry and had HCV entered on his or her problem list in the electronic medical record.

Number of Patients Treated With HCV Antivirals

Among patients in the HCV Clinical Case Registry linked to HCV care in 2013, we determined the number who had ever received HCV antiviral medications, including boceprevir, consensus interferon, interferon, pegylated interferon, ribavirin, and telaprevir, from the VHA at any time up to and including December 31, 2013.

Number of Patients With an SVR

We evaluated SVR rates using all HCV RNA results available after the end of treatment for those patients linked to HCV care in 2013 who had a calculated end of treatment included in the available data. We calculated the end of treatment as the last day covered by any HCV antiviral medication, using the cumulative number of days of medication supplied and the dispensed dates. We considered that patients with an undetectable HCV RNA on all tests after the end of treatment, including at least 1 test 12 weeks or more after the end of treatment, had achieved SVR; patients with a detectable HCV RNA after the end of treatment were considered not to have SVR. SVR status could not be definitively determined for patients who were still on treatment at the end of the available date, who had not had HCV RNA testing after the end of treatment, or who had an undetectable HCV RNA result after the end of treatment but no test 12 weeks or more after that date. We then applied the SVR rate among those evaluable for SVR to all those who had started HCV antiviral treatment to determine the number of patients in care in 2013 who would be expected to achieve SVR.

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RESULTS

Results for the 5 steps of our cascade of HCV care appear in Figure 1. Comparisons to national estimates for these same 5 steps appear in Figure 2.

Number of Patients With Chronic HCV

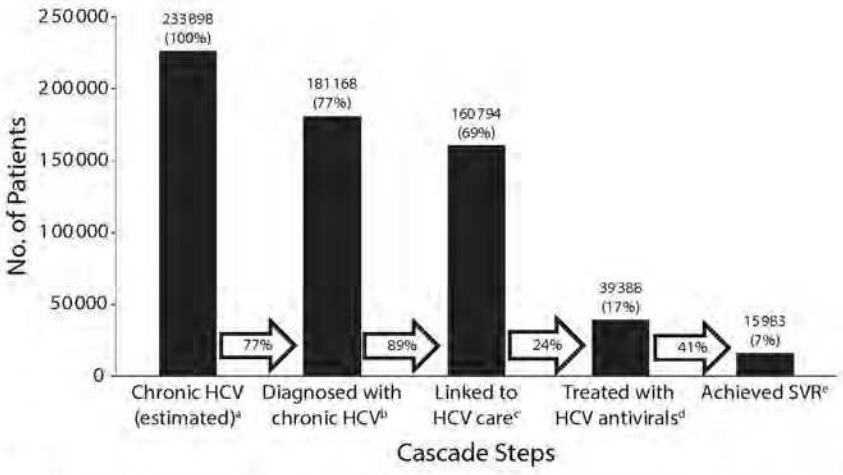
Overall, 5 596 178 patients had a VHA outpatient visit in 2013 and 3 135 396 (56.0%) had ever had any HCV testing (HCV antibody, viral load, or genotype) in the VHA; 3 117 014 (99.4% of those with any testing) had HCV antibody testing, 502 378 (16.0%) had viral load testing, and 191 552 (6.1%) had genotype testing.

Patients already identified with chronic HCV. Of 218 111 patients with positive antibody tests, 208 893 (95.8%) had RNA-based testing for chronic HCV. Of those with positive antibody tests who received RNA-based testing, 161 044 (77.1%) had positive RNA test results and therefore had chronic HCV. We identified an additional 20 124 patients with chronic HCV from RNA testing without preceding antibody testing. Overall, we identified 181 168 individuals who had an outpatient visit in 2013 as ever having chronic HCV, for a prevalence of 5.8% among those with informative testing.

Estimated additional cases from the projected prevalence among HCV antibody-positive patients who had not received RNA testing. Among those with positive antibody results, 9218 patients did not have RNA-based testing. Applying the observed prevalence among HCV antibody-positive individuals who did have RNA-based testing (77.1%) to the 9218 who did not have RNA-based testing, we estimated that an additional 7107 individuals would be identified with chronic HCV by RNA-based testing of these individuals.

Estimated additional cases from the projected prevalence among the untested population. Of the patients in VHA care in 2013, 2 460 782 had not been tested for HCV (excluding the 552 patients without gender [n=26] or birth-date information [n=526]). If the projected prevalence rates in each demographic cohort were applied, an estimated additional 45 623 patients with chronic HCV would be identified among the untested population in VHA care (Table 1).

The estimated total number of patients with chronic HCV (n=233 898) thus reflects the sum of (1) those already identified with chronic HCV (n=181 168), (2) estimated additional cases among those known to have positive HCV antibody without RNA testing (n=7107), and (3) estimated additional cases among untested patients (n=45 623).



Note. SVR = sustained virologic response. The proportion of patients in each step of the cascade from the patients in the preceding step is presented in the arrows between each bar.

[a]Chronic HCV was estimated from the sum of those already identified with chronic HCV plus estimated additional cases from projected prevalence among HCV antibody-positive patients who had not had RNA testing plus estimated additional cases from projected prevalence among the untested population.

[b]"Diagnosed with chronic HCV" was defined as ever had a detectable HCV RNA or genotype.

[c]"Linked to HCV care" required an outpatient visit in 2013, entry in the VHA's HCV registry, and HCV entered on the patient's medical record problem list.

[d]"Treated with HCV antivirals" was defined as ever received HCV antivirals from the VHA as of December 31, 2013.

[e]"Achieved SVR" was defined as undetectable HCV RNA on all tests after end of treatment, including at least 1 test at least 12 weeks after the end of treatment, with the SVR rate among those evaluable for SVR applied to those without definitive SVR status.

FIGURE 1—Cascade of HCV care in the Veterans Health Administration (VHA) in 2013 (n = 233 898).

Number of Patients Diagnosed With Chronic HCV

As noted in the previous paragraph, 181 168 (79.9%) of an estimated 233 898 patients in VHA care in 2013 with chronic HCV had been diagnosed with chronic HCV.

Number of Patients Linked to HCV Care

In 2013, 172 857 patients in the HCV Clinical Case Registry had at least 1 outpatient visit in the year. Of these, 160 794 had HCV entered on their problem list. By this definition, 88.8% of all patients in VHA care in 2013 with diagnosed chronic HCV had been linked to HCV care.

Number of Patients Treated With HCV Antivirals

Of the 160 794 patients linked to HCV care, 39 388 (24.5%) had ever received VHA HCV antiviral therapy as of December 31, 2013.

Number of Patients With an SVR

Of the 39 388 patients in care in 2013 who had ever received HCV antivirals from the VHA, SVR status could be determined for 37 069, of whom 15 041 (40.6%) achieved SVR. Conservatively, applying this SVR rate to the 2319 who did not have definitive SVR status and adding it to those known to have SVR, the projected number with SVR among those in care in 2013 who had received HCV antivirals was 15 983, or 6.8% of the entire population projected to have chronic HCV.

DISCUSSION

The high prevalence of chronic HCV, the rapidly changing treatment climate, and the

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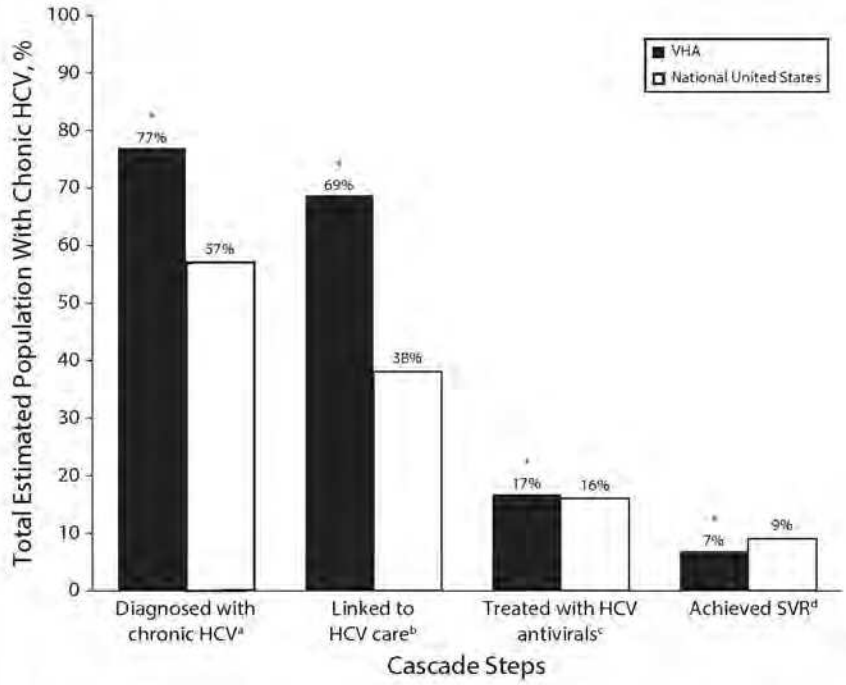

Note. SVR = sustained virologic response. Total estimated chronic HCV population in the VHA in 2013 was 233 898.
Source. National US estimates were derived from the following sources: diagnosed with chronic HCV,[16] linked to HCV care,[17] treated with HCV antivirals and achieved SVR.[11] VHA estimates were derived from the VHA Corporate Data Warehouse and the HCV Clinical Case Registry.
[a]"Diagnosed with chronic HCV" was defined as ever had a detectable HCV RNA or genotype.
[b]"Linked to HCV care" required an outpatient visit in 2013, entry in the VHA's HCV registry, and HCV entered on the patient's medical record problem list.
[c]"Treated with HCV antivirals" was defined as ever received HCV antivirals from the VHA as of December 31, 2013.
[d]"Achieved SVR" was defined as undetectable HCV RNA on all tests after end of treatment, including at least 1 test at least 12 weeks after the end of treatment, with the SVR rate among those evaluable for SVR applied to those without definitive SVR status.
*$P < .001$.

FIGURE 2—Cascade of HCV care within the Veterans Health Administration (VHA) and relative to national US estimates in 2013.

high cost of antiviral therapies all warrant the use of a population health approach to HCV care. Our cascade of HCV care demonstrates that the VHA performs very well in the initial steps of the cascade and outperforms national US estimates (Figure 2). For example, the VHA has diagnosed an estimated 77.5% of its patients in care with chronic HCV. This compares with national US estimates from the Chronic Hepatitis Cohort Study that suggest that only 57% of those with chronic HCV have been diagnosed.[16] The VHA also performs well in linking patients to HCV care: 69% of patients with chronic HCV (89% of those with diagnosed chronic HCV) have been linked to HCV care. National US estimates indicate that only 38% of patients with chronic HCV (77% of those with diagnosed chronic HCV) have been linked to HCV care, when linkage to care is defined as self-reporting a visit with a health care provider after receiving a positive HCV test.[17] We posit that the decrement between being diagnosed with chronic HCV and being linked to HCV care is smaller within the VHA (a decrement from 77% to 69% within VHA, vs 57% to 38% within the United States; Figure 2), in part because of higher HCV diagnosis rates within VHA, as well as differences in definitions of "linked to care." A clinically meaningful, readily accessible measure of "linked to care" is difficult to define; we believe our definition is most appropriate given the availability of the Clinical Case Registry as a resource, as well as the relative ease of using electronic medical records to extract problem list entries.

This cascade illuminates important opportunities to improve care within a health care system. Within the VHA, as of the end of 2013 before the availability of interferon-free regimens, only 17% of patients with chronic HCV (24% of those linked to HCV care) had received antiviral treatment. This figure is similar to that of Yehia et al., who estimated that 16% of HCV-infected individuals have received treatment in the United States.[11] The model also documents the historically low SVR rates from prior interferon-based HCV antiviral regimens. In the VHA, approximately 41% of the patients who had ever been treated with HCV antivirals through Dec 31, 2013—and 7% of all patients with chronic HCV—achieved SVR, comparable to the estimated national SVR rates of 9%.[11] Although all steps of the cascade require attention, within the VHA health care system increasing treatment initiation will have the largest impact on increasing cure rates. Both the treatment rates and SVR rates have already improved markedly with the availability of shorter-duration, highly efficacious treatment regimens.

This cascade provides a health care system with a method to assess and monitor over time the quality of its HCV care and to identify performance metrics that require improvement. The information this model generates is useful across a broad range of reporting units, so that a large health care system may identify variation between regions or facilities and appropriate targets for performance improvement interventions. The cascade uses data that are typically available within a health care system's electronic medical record, thereby encouraging health care systems to use this model to monitor their own HCV care and enabling them to compare the quality of their HCV care with that of other systems. Additionally, since it mirrors the flow of clinical care from diagnosis to cure, it provides relevant information to clinicians and administrators: How many patients do we have with chronic hepatitis C? How many have been treated? How many have been cured?

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TABLE 1—Projected Prevalence of HCV in 2013 Among Veterans Health Administration Patients Who Were Previously Untested, by Sociodemographic Characteristics: United States

Characteristic	Born Before 1945			Born Between 1945-1965			Born After 1965		
	No.	Projected Prevalence,[a] %	Estimated No. of Cases	No.	Projected Prevalence,[a] %	Estimated No. of Cases	No.	Projected Prevalence,[a] %	Estimated No. of Cases
Women									
American Indian/Alaska Native	122	0.00	0	618	0.84	5	819	0.00	0
Asian	99	0.00	0	505	0.90	5	1 447	0.00	0
Black	1 184	0.00	0	16 940	1.18	200	19 323	0.13	25
White	15 190	0.05	8	34 294	1.04	357	33 605	0.54	181
Hispanic	390	0.00	0	2 103	0.64	13	6 136	0.13	8
Native Hawaiian/Pacific Islander	148	0.00	0	443	0.50	2	687	0.00	0
Mixed, other, or unknown	2 675	1.52	41	8 514	1.92	163	10 896	0.22	24
Subtotal			49			745			238
Men									
American Indian/Alaska Native	4 497	1.71	77	6 379	5.87	374	3 185	0.26	8
Asian	6 157	0.58	36	6 734	0.72	48	5 728	0.11	6
Black	66 442	1.86	1 236	122 370	6.85	8 382	53 566	0.27	145
White	820 785	0.45	3 694	567 756	3.62	20 553	198 289	0.80	1 586
Hispanic	29 245	1.57	459	35 512	4.84	1 719	28 687	0.41	118
Native Hawaiian/Pacific Islander	6 445	0.67	43	5 529	1.70	94	2 811	0.23	6
Mixed, other, or unknown	169 155	0.86	1 455	113 287	3.90	4 418	51 533	0.26	134
Subtotal			7 000			35 588			2 003

Note. The total estimated number of HCV cases among those untested was 45 623.
[a]Projected prevalence is based on the incident diagnosis rate in those first tested in 2013 multiplied by the ratio of the 2013:2012 incident diagnosis rates.

Although our model offers many benefits, there are limitations to this approach. Even after incorporating the decline in incident diagnosis rates from 2012 to 2013 and the variability by gender, race/ethnicity, and birth cohort, the projected prevalence rates for the untested likely still overestimate the number of additional cases that would be identified with complete population testing, particularly in the birth cohorts born before 1945 and after 1965. For these 2 cohorts, risk-based screening is recommended.[18] Thus, the observed incident diagnosis rates are likely higher for these patients who have been identified as at risk and tested compared with the rate that would be observed among those who are untested and theoretically not at risk. Even with this overestimation, however, only 9290 (20.4%) of the estimated 45 623 additional cases that would be found with testing the untested occur among those born outside the 1945 to 1965 birth cohort. Although changes in the estimates of the undiagnosed would change the absolute percentages, the percentage changes from preceding steps along the cascade would not change. The percentages of each preceding step provide useful information for identifying gaps in care—for example, regardless of the estimate of the undiagnosed, only 24% of those linked to HCV care have received antivirals.

Another limitation is that our definition of "linked to care" relies partly on the entry of patients with chronic HCV into the HCV Clinical Case Registry, a VHA registry of individuals with chronic HCV that is not available in other health care systems. However, other health care systems may have similar ways of tracking HCV among their patient populations. Finally, the SVR estimates provided here reflect a static number that relies heavily on patients who received therapy during a period of less efficacious interferon-based treatments. Although SVR rates are increasing with the rapid uptake of more efficacious regimens, there will be a delay in observing the impact of this increased effectiveness at the population level. Moreover, our SVR estimates would not capture patients who received HCV antiviral therapy and achieved SVR outside the Department of Veterans Affairs health care system.

Our cascade of HCV care offers health care systems the ability to readily measure and monitor performance during a period of rapid change in the field of HCV treatment and care. The dramatic improvements in HCV treatment effectiveness pose parallel challenges to public and private health care systems grappling with high treatment costs and inadequate numbers of trained providers to meet the demand for HCV care. This cascade is a useful tool for systems aimed at maximizing provider and fiscal resources to improve the overall quality of HCV care. ■

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Contributors

M. M. Maier and M. Chartier contributed to data analysis. P. S. Belperio and L. I. Backus were instrumental to data production and analysis. All of the authors contributed to the study design and the preparation and revision of the article.

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Human Participant Protection

Under guidance from the VHA Office of Research Oversight, the Office of Public Health has the authority to perform the analyses presented here as part of their health care operations work, which does not require institutional review board approval.

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 4:59:22 PM
To: (b) (6) va.gov; (b) (6) va.gov; (b) (6) hotmail.com
Subject: Hepatitis paper
Attachments: hepatitsC.docx

(b) and (b) (6) and Poonam- you did a spectacular job writing this up and its a remarkable story that has occurred at VA.
I think this is exactly the type of manuscript that is needed so others can benefit from your experience and also that VA can be appropriately recognized for its' leadership in this area.

I surprisingly made very few edits or corrections in the paper which is a real tribute to you all.
Please take a look and make sure you agree with these few changes.

The one request I would make is to be an author on this paper I feel it is important that I review the data that you used to put the statistics in the paper about how many veterans we treated and our success rates.
Do you have any reports or data that you could share so Dr. Alaigh and I can review before we put our names on the manuscript?

I don't know if Dr. Alaigh has had time yet to review.

The annals seems appropriate or if not a hepatology journal surely would be interested.

Thanks so much for your leadership here

David Shulkin MD

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Curing Hepatitis C Infection: Best Practices from the Department of Veterans Affairs

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Keywords: Veteran, access, direct acting antiviral, cascade

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Introduction

Since the introduction of Direct Acting Antivirals (DAAs) in 2014, the Department of Veterans Affairs (VA) has made substantial progress in curing the large number of veterans in VA care with hepatitis C virus (HCV) infection. As the nation's single largest provider of care to patients with HCV, VA is uniquely suited to inform the recently released *National Strategy for the Elimination of Viral Hepatitis,* produced by a National Academies of Sciences, Engineering, and Medicine expert committee, which emphasizes prevention, screening, and universal treatment of HCV-- areas in which VHA has become a recognized leader.[1,2] The proposed national strategy presents specific actions to reduce the burden of HCV and outlines 5 distinct areas—*Information, Interventions, Service delivery, Financing, and Research*.[1,2] ~~Herein,~~ VA's best practices and successes may be useful to other healthcare providers and organizations in helping to reduce the burden of hepatitis C infection. ~~in each of these areas are highlighted.~~

Based on US National Health and Nutrition Examination Survey (NHANES) data from 2010, it was estimated that approximately 13% of all patients diagnosed with HCV in the United States (US) receive care within the VA, highlighting the disproportionate burden among veterans.[3,4] In 2013, before the availability of HCV DAAs, there were approximately 168,000 veterans diagnosed with HCV infection in VA care who were potentially eligible for treatment and an additional estimated 45,000 undiagnosed in care.[5]

With support from the US House and Senate Appropriations Committees, VA has made a substantial commitment to prioritizing HCV care as reflected in dedicated funding for HCV treatment in VA, universal access to DAAs, detailed guidance on individualizing care and the establishment of Veterans

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Integrated Service Network (VISN) Hepatitis C Innovation Teams (HITs).[6] This work, in collaboration with other key VA offices, is largely supported by the VA's National Viral Hepatitis Program which also develops policy, tools, trainings, and resources for patients and providers, easily accessible through internal channels and on its comprehensive website.[7] VA's success and best practices, informed by extensive population health data analysis capabilities, and national ~~tools,~~ guidance and policies~~, is due to the dedicated providers and teams on the ground~~.

The significant resources and efforts VA and its HCV providers have dedicated to prioritizing this disease at every level of the organization are being tangibly realized. Between January 2014 and March 2017, 86,000 HCV-infected veterans enrolled in VA care have received potent oral DAA treatment, achieving cure rates of over 90%. As of March 2017, only 58,000 known veterans in VA care remain to be treated, compared to over 168,000 three years ago. While elimination appears attainable, VA recognizes the reality of the HCV epidemic and population; namely, many of those in care remaining to be treated have complex substance use, mental health, and medical co-morbidities, and many are challenged by homelessness, transportation, and rurality which pose significant barriers to engagement in care and treatment. The curve of elimination for HCV in VA will include a long tail of persistence driven by system, patient and care delivery determinants (Figure 1).

Information: Population Health Management

Using ~~robust~~ national databases and analytics, VA employs population health management strategies to ~~efficiently~~ track, measure, monitor and identify trends in HCV care, gaining insight into patterns of access and tailoring care provision programs accordingly. ~~Every~~ Veterans in VA care diagnosed with HCV is followed in VA's National Hepatitis C Clinical Case Registry (CCR), developed in part to ensure veterans with chronic HCV were linked to care .[8] The HCV CCR, used for both local and national

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population reporting, provides data on the number of patients known to be infected with HCV together with critical clinical information such as patient and disease characteristics, where care is received, receipt of DAA treatment and clinical outcomes. The VA's Central Data Warehouse, a repository of electronic medical record data, has spurred the creation of local and regional HCV dashboards which offer providers access to patient-specific data reports for real-time intervention and tracking. These sources allow for comprehensive monitoring of incidence, prevalence, and disease course to identify and address barriers and assess outcomes. National, regional and individual facility level data is posted regularly, allowing providers, teams, and leadership to assess progress and goals. This leveraging of health systems data transforms numbers into knowledge and guides providers and the VA toward more informed and effective delivery of care for each veteran.

Essential Interventions

Diagnosis and Testing

Improved case identification: A critical first step for improving HCV care is to identify those infected. In 2012, the Centers for Disease Control and Prevention (CDC) and subsequently the United States Preventive Services Task Force (USPSTF) developed recommendations for testing ~~everyone~~veterans born between 1945-1965, a cohort determined to have the highest HCV prevalence .[9-10] Prior to 2014, VA had guidance in place which recommended risk-based testing as well as testing of Vietnam-era veterans, a group which largely overlaps with the 1945-1965 birth cohort.[3] Using robust information systems to track screening, VA has been able to identify and target additional populations at risk for HCV, which include: African American males, for which the prevalence is double that of Caucasians (17.7% versus 8.3%); the homeless, for which the prevalence is over three times higher when compared to non-homeless (13.4% versus 3.5%); and persons who inject drugs.[11-12]

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Since the rapid adoption of these expanded screening recommendations, VA has successfully screened over 78% of the 2.5 million veterans in the 1945-1965 birth cohort. Of particular note, VA has screened 89.6% of its homeless population.[12] Using updated annual prevalence calculations from the number of new infections among those tested, VA estimates that there are only approximately 15,000 remaining veterans in VA care who would test positive for HCV if the entire at-risk population were screened.

Testing initiatives: Several initiatives undertaken within VA to increase HCV testing have significantly impacted these results. These include national electronic point-of-care clinical reminders for HCV risk assessment and testing, automated letters recommending HCV testing which dually serve as a laboratory order when presented to a VA lab, weekly primary care panel review identifying patients with upcoming appointments who require testing, and calling patients directly. To emphasize this as a priority, VA added birth cohort testing as a national performance measure in 2015 and reports quarterly screening rates by facility and region. To ensure complete testing while simultaneously providing an efficient and patient-centered approach, VA developed policy in 2009 whereby all patients tested for HCV with a positive antibody automatically had reflex confirmatory HCV RNA testing performed with the same laboratory sample, with over 97% compliance in 2015. As a result of these collective factors, the proportion of veterans in VA care screened for HCV have increased annually by 3% to 4% and are substantially higher than any other large healthcare systems.[13]

Building Infrastructure

Hepatitis Innovation Team (HIT) Collaborative: Recognizing that care is not delivered the same way in all settings, regional HITs, comprising a multidisciplinary group of 15-30 healthcare providers, administrators, information technology and system redesign specialists, have implemented Lean Process Improvement methods to maximize their clinical expertise and redesign the process of HCV testing, diagnosis, treatment, and management to provide care in the most efficient and effective way possible for

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the populations they serve.[14] The HIT Collaborative has enabled a clinically focused foundation to share and implement best practices across and within teams, supported by local and regional administrators. The development of the HIT infrastructure on the ground which has leveraged and supported the work of dedicated VA providers has been one of the critical implementation arms that has allowed VA to nimbly respond to challenges in funding variability and other critical access issues that have arisen since the introduction of DAAs.

Service Delivery: Improving Linkage and Access

Once an enrolled veteran is diagnosed with HCV, the emphasis shifts to timely linkage to evaluation and referral for appropriate treatment. Robust population health data, the infrastructure of the HIT collaborative, and legions of dedicated providers on the ground have been instrumental in enhancing VA's outreach and engagement efforts. Efforts have focused on raising awareness among providers and staff about the need for HCV testing and availability of treatment, as well as promoting direct outreach to at-risk veterans and the veteran community more broadly through national and local social media and advertising campaigns, mobile phone applications, and secure messaging.

Expanding Capacity

Telemedicine and electronic technologies: VA has focused on increasing specialist capacity through telemedicine and clinical video telehealth (CVT), or real-time video teleconferencing, whereby HCV clinicians provide care to patients and/or consultation to other providers at another location. Largely modeled off of the University of New Mexico ECHO project,[15] the expanded VA-ECHO model includes urban and rural sites, homeless care clinics and incorporates a pharmacist-led provider program since much of HCV treatment in VA is managed by clinical pharmacists and an HCV mental health and

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substance use program to aid providers in treating patients with these co-morbidities. Inter-provider electronic consults offer another effective and efficient way to prepare patients for treatment avoiding the need for additional appointments. Using electronic databases, registries or dashboards, HCV team members can identify patients who may be candidates for treatment, notify primary care providers electronically through the medical record of their eligibility and recommend management. Similarly, primary care providers can efficiently consult HCV specialists regarding HCV care management and treatment recommendations eliminating the need for a specialty visit.

Non-physician advanced practice providers: Importantly, VA has also emphasized the expansion of HCV care beyond specialty providers. A substantial portion of HCV management has shifted, particularly treatment, outside of liver and infectious disease specialty care clinics at larger medical centers to primary care and community clinics. Furthermore, this care is often being delivered by non-physician providers such as Clinical Pharmacy Specialists, Nurse Practitioners and Physician Assistants, who have been recognized as delivering the same quality of care and providing more timely access to HCV treatment.[16-17]

In 2016, almost one-third of all HCV antiviral prescriptions were initiated by a network of nearly 200 Clinical Pharmacy Specialists.[18] Targeted use of the limited number of specialists while expanding the skills of non-physician providers is one of the most important practices that can be adapted from the VA system into other healthcare systems.[16] VA has recently granted full practice authority to nurse practitioners therefore expanding the potential for further use of these providers in providing hepatitis care.

Challenging Populations

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Barriers to Care: Based on VA HCV provider data collected in 2014 and 2015, it was estimated that up to 30% of veterans awaiting treatment were not currently willing or were unable to initiate HCV treatment. Major reported reasons included active alcohol/substance use, serious mental illness, documented non-adherence to medical appointments or treatment, unstable/uncontrolled medical comorbidities, inability to contact a veteran and, in some cases, veterans being unwilling to start treatment. As VA continues to treat more patients, an increasing number of those remaining in the untreated pool present more challenges, with accompanying resource demands to potentially modify these patient, system, or care delivery factors. Frequent reassessment and refocusing is required of healthcare systems and providers to adapt their approach and resources as the needs of its HCV population and barriers to initiating treatment change.

Addressing substance use: Recognizing alcohol and substance use as a considerable barrier to HCV treatment, VA took aggressive steps to eliminate non-evidence based, abstinence policies for HCV treatment and provided clinical guidance on effectively assessing alcohol and substance use, matching a patient's use with the actual risk of non-adherence. VA studies have consistently shown cure rates achieved among veterans with alcohol, substance use and mental health disorders are similar to those without these conditions.[19-20]

Integrated care: Where resources permit, VA has emphasized that integrated care, care coordination, case management, and mental health and substance use services are in place to address factors that pose significant impediments to HCV treatment. This comprehensive management approach facilitates care such that veterans' treatment candidacy can be reassessed. This has been particularly important for vulnerable populations. Accessible mental health and addiction specialists, care coordinators, case managers and social workers are invaluable resources to meet the individualized needs of this population.

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Financing HCV Treatment

Like all healthcare systems, VA has faced significant financial challenges as a result of highly priced DAAs. With strong advocacy from VA HCV providers, veterans and VA leadership expanded special purpose funding for HCV medications was made available through Congressional appropriations.[6,21] The dramatic reductions in the price of DAAs made possible by VA Pharmacy Benefits Management leadership steadfast negotiations in early 2016, simultaneous enactment of additional appropriations and removal of restrictions based on stage of liver disease solidified VAs ability to provide consistent access to HCV treatment. Currently, VA has no restrictions on DAAs which are available to all HCV patients regardless of stage of liver disease. Figure 2 depicts the significant impact of funding variability on DAA uptake in VA over recent years.

Recognizing that in order to comprehensively and successfully treat HCV infection in VA, resources beyond purchasing medications would be required. In 2016, VA boldly allocated 5% of the HCV drug budget for each VA medical center to non-drug clinical resources and infrastructure to further increase treatment starts. This has allowed VISN HITs to independently address local barriers and identify tangible solutions to increase treatment. These funds have successfully been used to expand HCV or liver disease VA-ECHO programs, increase treatment capacity through a Clinical Pharmacy Specialist initiative, increase integrated care, implement HIT innovations, host HCV testing events and fund local testing and treatment advertising campaigns.

Research to Inform

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The comprehensive data sources within VA and the VA's diverse HCV population provides a broad milieu for examining scientific and clinical outcomes, cost-effectiveness, patterns of care, and the impact of specific interventions. VA HCV researchers actively contribute to the medical literature influencing and informing patient care, implementation strategies, operations and policy. Given the large number of HCV-infected veterans treated, real-world outcomes in special populations can be assessed to a greater degree than in many other healthcare environments thus providing valuable insight for other payors and healthcare systems.

Cascade of HCV Care in VA

The impact of DAAs on HCV has been universally transformational, making elimination seem a tangible goal, as the National Academies of Sciences, Engineering, and Medicine report highlights. Elimination can only occur when every individual with HCV infection is identified, linked to care, treated with HCV antivirals and achieves a sustained virologic response (SVR), or cure. These steps comprise the "hepatitis C cascade of care", a series of key care components used to describe the population health approach to HCV care and a mechanism to assess performance.[5,13,22-24]

Figure 3 depicts VA's HCV transformation since the availability of DAAs and the impact on each of the steps of the care cascade from 2014-2016. As of 2016, VA estimates that 92% of veterans with HCV in care have been diagnosed, and of those, 93% have been linked to care. The most significant change in the cascade has occurred in the treatment step. In 2014, the VA had initiated HCV treatment in 27% of veterans linked to VA care. In turn, 51% achieved SVR. By the end of 2016, HCV treatment had been initiated in 59% of veterans linked to VA care, and 84% of the veteran population ever receiving HCV treatment had achieved SVR. Overall, 84,192 veterans have been cured of HCV, the overwhelming majority since 2014.

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Summary

The widespread availability of oral DAA medications that cure HCV have made the possibility of elimination seem achievable. VA is steadily approaching this goal and remains committed to diagnosing and treating all veterans with HCV who are willing and able to be treated. An extensive array of delivery of services, policy guidance, outreach efforts and funding has broadened the reach and capacity of VA to deliver these disease-curing medications, supported by an infrastructure to effectively implement change. The key actions that have advanced VA's HCV elimination efforts include: expanding treatment capacity with non-MD providers; use of video telehealth and modified ECHO models to expand treatment; widespread use of integrated care and improvement in addressing psychiatric, substance use and medical co-morbidities; use of electronic data tools for patient tracking and outreach; and dissemination and implementation of best practices developed through the Systems Redesign efforts of regional HITs. However, it must be underscored that financing for HCV treatment and infrastructure resources coupled with reduced drug pricing has been paramount to VA's success in curing HCV and is the lynch pin in achieving elimination for any health care system and the US nationally. Recognizing the resources necessary to realize this goal and the infrastructure and innovations that could make it truly possible, VA is well poised to share and extend best HCV practices to other healthcare organizations and providers delivering HCV care.

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Figure 1. Number of Veterans with HCV in VA Care Requiring Antiviral Treatment Over Time

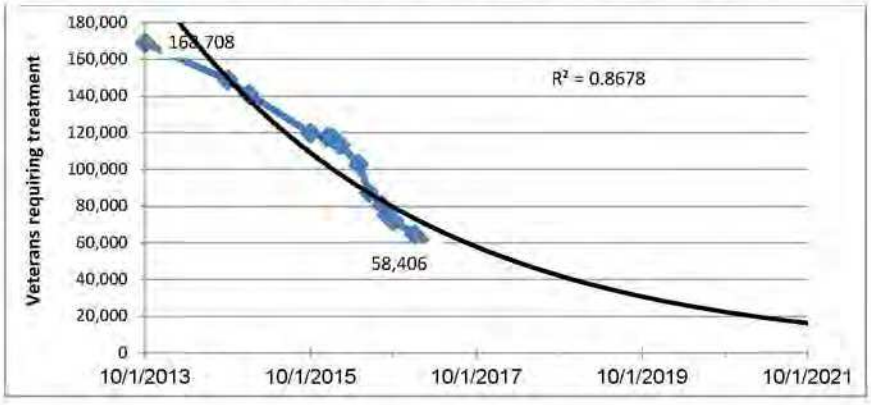

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Figure 2. Availability of Funding and Impact on HCV Treatment Starts per Week

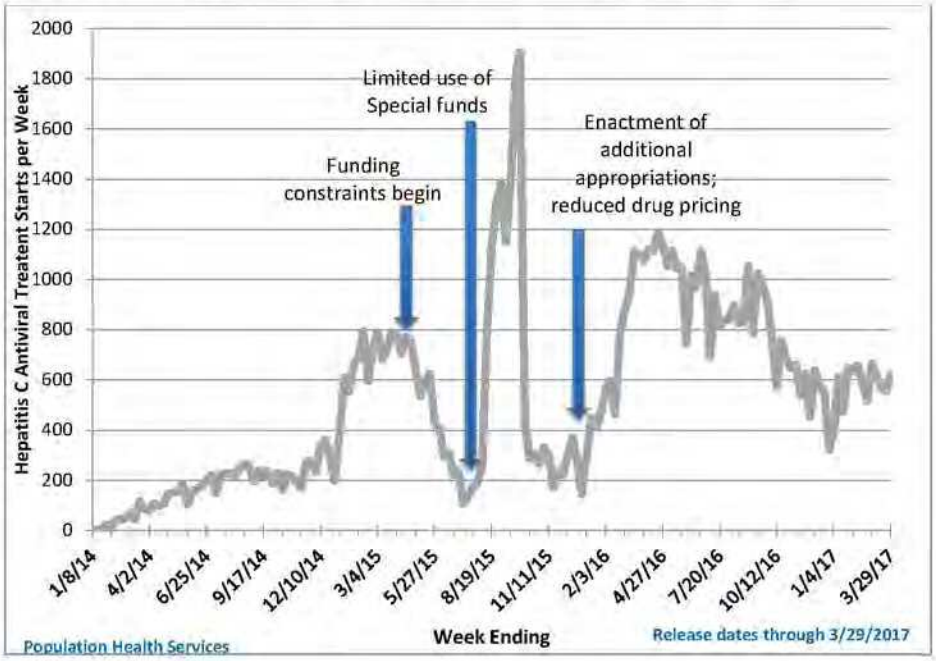

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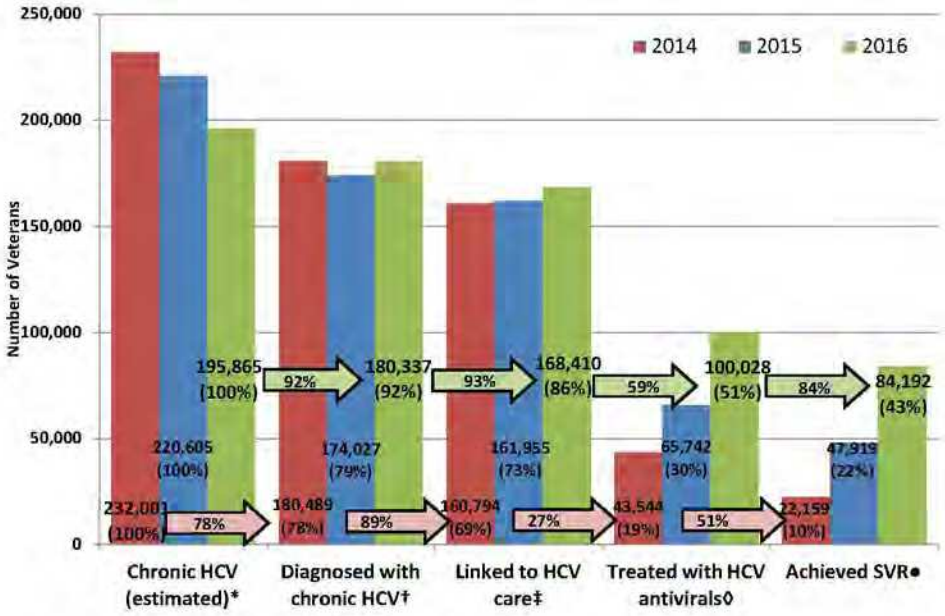
Figure 3. Cascade of HCV care in the Veterans Health Administration (VHA) in 2014, 2015, and 2016



The proportion of patients in each step of the cascade from the patients in the preceding step is presented in the arrows between each bar. SVR = sustained virologic response

*Estimated from diagnosed+ratio of prevalence in birth cohort strata in those tested in prior two years applied to those still untested

†Diagnosed with chronic HCV defined as ever had a detectable HCV RNA or genotype.

‡Linked to HCV care required an outpatient visit in the year, entry in the VHA's HCV registry and HCV entered on the patient's medical record problem list.

◊Treated with HCV antivirals defined as ever received HCV antivirals from VHA as of 31 December of the year.

●Achieved SVR defined as undetectable HCV RNA on all tests after end of treatment including at least one test at least 12 weeks after the end of treatment

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Acknowledgments: VA would like to thank all of the VA providers, Veterans, and Congressional appropriators who have contributed to VA's success in curing so many Veterans with HCV.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 11:36:54 AM
To: (b) (6) [(b) (6) va.gov]
Subject: Fwd: [EXTERNAL] Hepatitis paper

Please print

Sent from my iPhone

Begin forwarded message:

From: Poonam Alaigh <(b) (6) hotmail.com>
Date: April 18, 2017 at 7:23:40 AM EDT
To: David shulkin <Drshulkin@aol.com>
Cc: "(b) (6) <(b) (6) va.gov>, "(b) (6) <(b) (6) va.gov>
Subject: Re: [EXTERNAL] Hepatitis paper

I am in concurrence with Dr Shulkin- thanks

Sent from my iPhone

On Apr 18, 2017, at 7:16 AM, David shulkin <Drshulkin@aol.com> wrote:

Thank you

Sent from my iPhone

On Apr 18, 2017, at 1:06 AM, (b) (6) (b) (6) va.gov> wrote:

Hi Dr. Shulkin and Dr. Alaigh,

Please find attached the data on the number of veterans we have treated and our SVR (cure) rates among those we have treated since the availability of the oral DAAs.

In the attached spreadsheet (HCV VA data sources.xls), please find three tabs:

Tab 1 shows the daily cumulative total of veterans starting on oral HCV DAAs. We started prescribing in VA in Jan 2014, though they were FDA approved in Nov 2013. This summary graph is also posted and is available at the first link listed below.
Number of veterans treated since DAA availability:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/default.aspx

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Tab 2 of the spreadsheet shows the number of veterans *awaiting treatment* at periodic intervals beginning with FY14 (DAAs introduced in VA in Q2 FY14). This is data captured from the HCV Clinical Case Registry. Those in the paper reflect the end of March (Q2 FY17).
This data is also posted and is available at the link listed below:
Numbers *awaiting* treatment – this is updated quarterly.
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Viremic/viremic-fib4.aspx

Tab 3 of the spreadsheet shows the raw data that relates to the "Cascade of HCV Care" (figure 3) with a brief sentence about the methods used to calculate each "step". For more detailed methods, refer to the attached Maier et al paper. We used the same methods for the current cascade as we did in this previously published paper. Note that the cascade numbers represent all HCV patients in care *ever treated* (even with earlier non-DAA regimens before 2014) which is why the SVR percentages in the cascade graph are lower than what the SVR rates are with all oral DAA regimens (shown in link below – which represent SVR rates of only oral DAA regimens from 2014 and beyond).
SVR (cure) rates with *all oral DAA regimens* are posted here and updated every two weeks:
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvantivirals/HCV%20Antivirals%20Tests/HCV_Direct_Acting_Antivirals.aspx
From table at above link, SVR rate calculated as SVR12/(NoSVR+SVR12) = 94.98%; Published data on SVR rates available in the attached article.

HCV testing rates are updated and posted quarterly, (those in the paper reflect the end of March, Q2 FY17) :
https://vaww.vha.vaco.portal.va.gov/sites/PublicHealth/pophealth/hcvbirthcohort/hcv_cohorts_fiscal_year/default.aspx

Please let me know if you have any additional questions about the data or would like to have copies of any of the other references in the paper.

Best,
(b)

From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Sunday, April 16, 2017 9:59 AM
To: (b) (6) (b) (6) (b) (6) hotmail.com
Subject: [EXTERNAL] Hepatitis paper

(b) and (b) (6) and Poonam- you did a spectacular job writing this up and its a remarkable story that has occurred at VA.
I think this is exactly the type of manuscript that is needed so others can benefit from your experience and also
that VA can be appropriately recognized for its' leadership in this area.

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I surprisingly made very few edits or corrections in the paper which is a real tribute to you all.
Please take a look and make sure you agree with these few changes.

The one request I would make is to be an author on this paper I feel it is important that I review the data
that you used to put the statistics in the paper about how many veterans we treated and our success rates.
Do you have any reports or data that you could share so Dr. Alaigh and I can review before we put our names on the manuscript?

I don't know if Dr. Alaigh has had time yet to review.

The annals seems appropriate or if not a hepatology journal surely would be interested.

Thanks so much for your leadership here

David Shulkin MD

<HCV VA data sources.xlsx>

<Maier_AJPH201512546R3_2nd_ProofCXs.pdf>

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 6:35:54 PM
To: (b) (6) [(b) (6) its.jnj.com]
CC: IP [(b) (6) frenchangel59.com]; Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
Subject: J&J

Thank you for taking the time to discuss with me how to move this important mental health initiative forward in time for mental health awareness month. As we discussed both your CEO (b) (6) and my CEO's representing the five academic centers know and respect Terry Fadem's ability to get the precision medicine, clinical trials and preventive medicine done in a timely manor. Let's move quickly on the narrative and marketing material as discussed. Again I am available 24-7 to assist.

Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/22/2017 3:29:16 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]

From this morning

http://www.cbsnews.com/videos/va-secretary-david-shulkin-on-challenges-facing-the-agency/?ftag=CNM-00-10aab4i

Sent from my iPhone

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/20/2017 1:37:32 AM
To: (b) (6) [redacted]gmail.com
Subject: Fwd:
Attachments: healthdatapoolza.pptx

You did a good job. Attached are my revisions

Good to go if you can fill in the big data announcement slide and make sure the clip works

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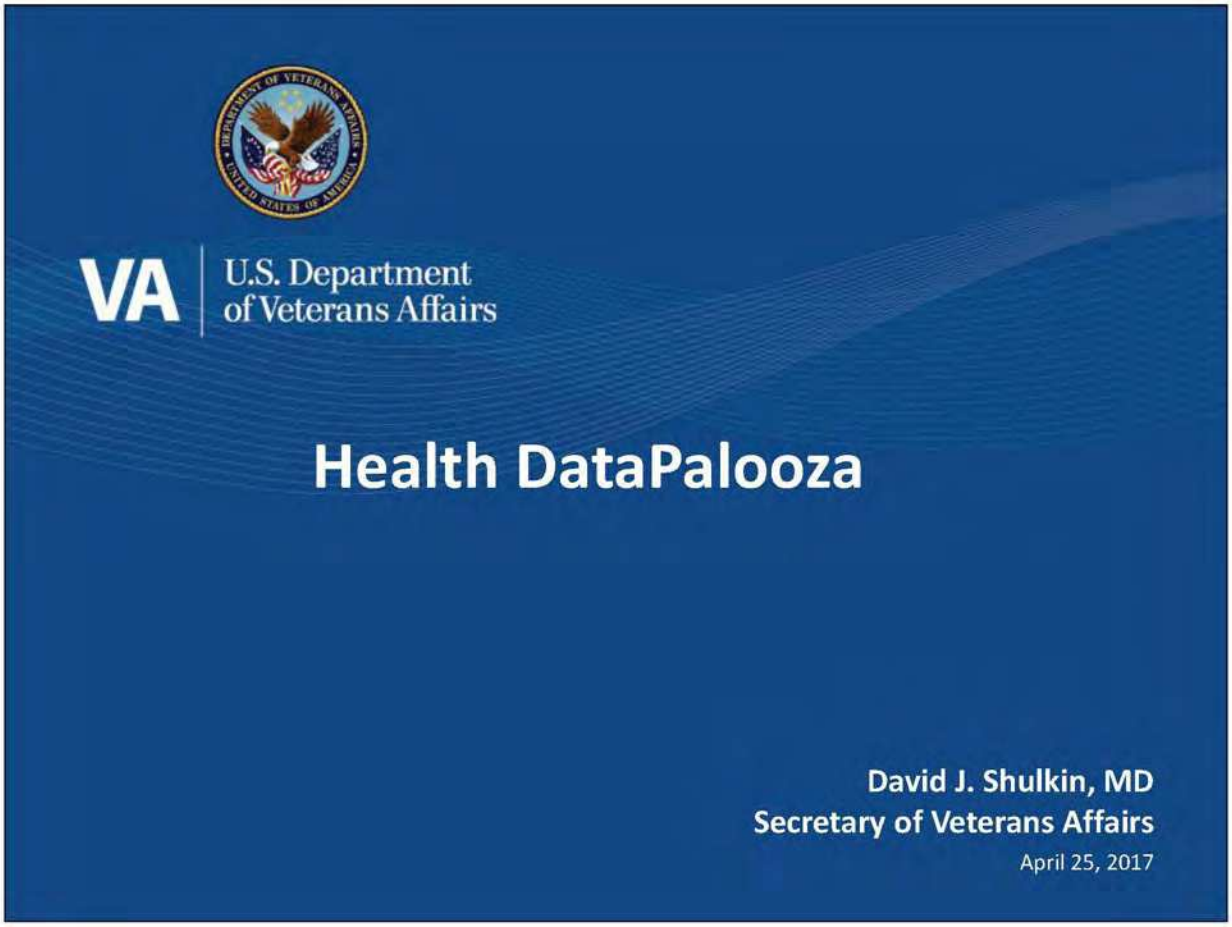
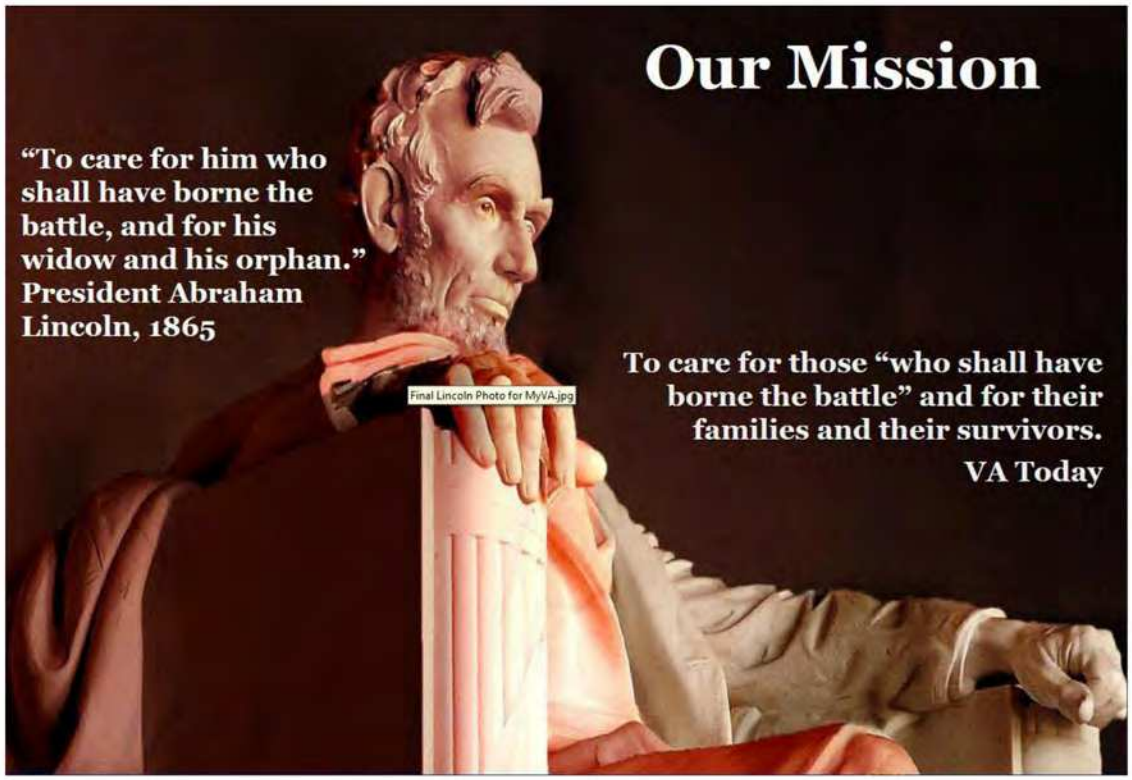


AMERICAN OVERSIGHT



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"Out of crisis comes clarity."

Randolph O'Toole

AMERICAN OVERSIGHT

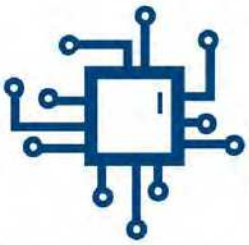
VA-19-0799-D-000296

DS_00001962

Top 5 Priorities for VA



Greater Choice



Modernize Systems



Focus Resources



Improve Timeliness



Suicide Prevention

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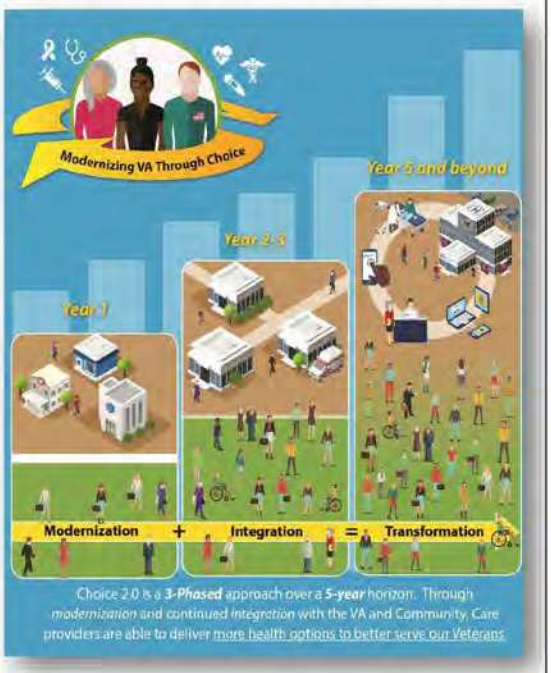
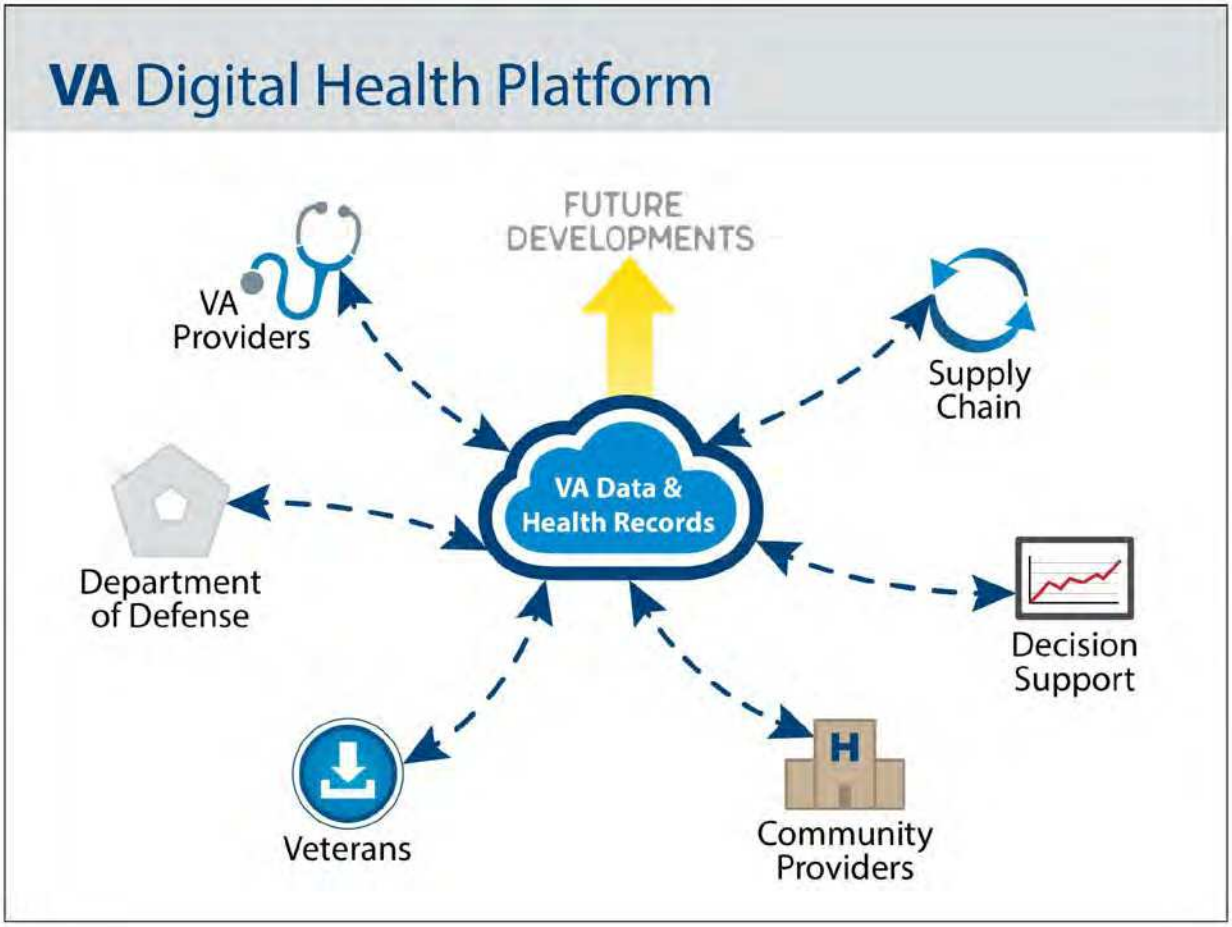
1- Greater Choice for Veterans

- Redesign the 40/30 Rule
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information



VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT



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Delivering Care Where We Don't Have Facilities





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VA Telehealth Services

2.14 million episodes to 677,000 Veterans (12%)



Home Telehealth
156,000 Veterans



Video Telehealth
282,000 Veterans



Store-and-Forward Telehealth

298,000 Veterans

45% of our Telehealth services are for rural Veterans

336,000 TeleMental health visits

8

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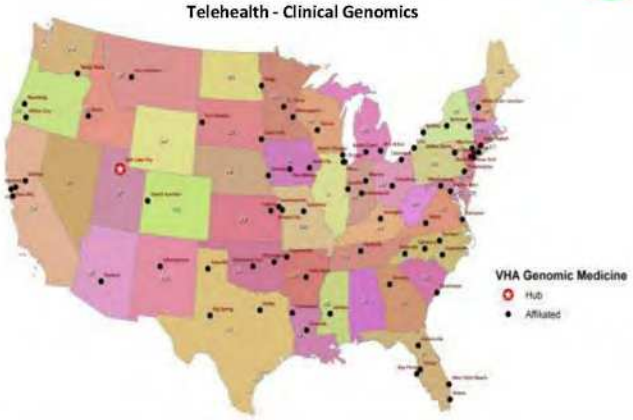
Tele-ICU Hubs

VISN 10 Tele-ICU program (Cincinnati)

Connects to other facilities Intensive Care Units



Telehealth - Clinical Genomics



TeleRadiology Program



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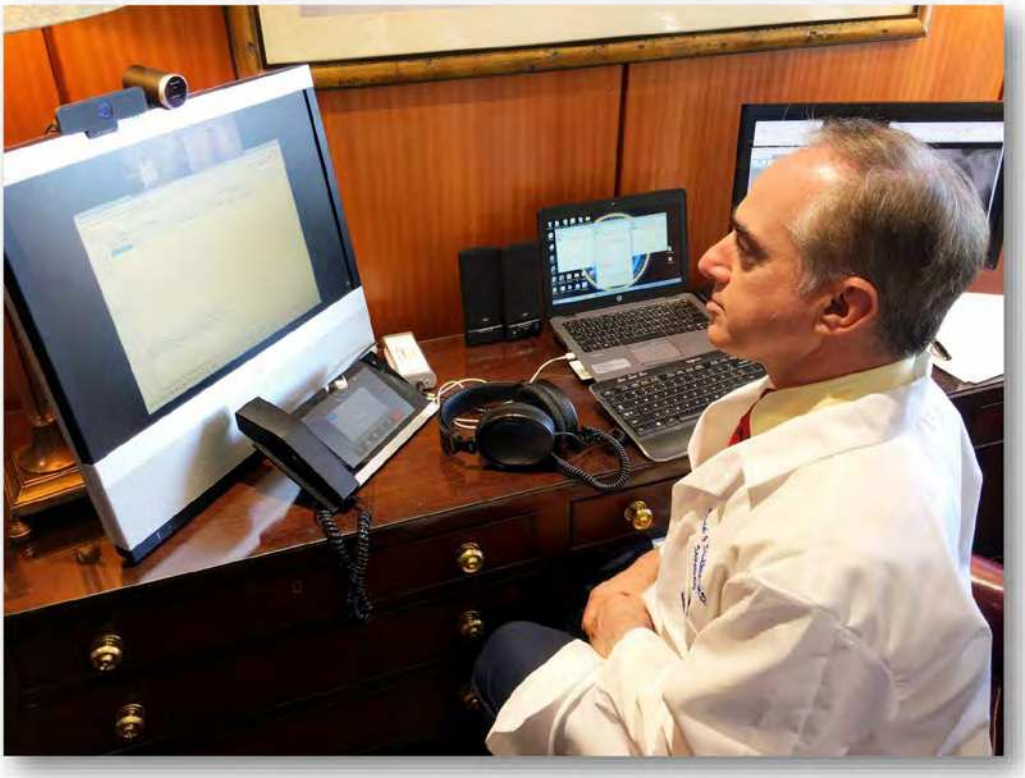

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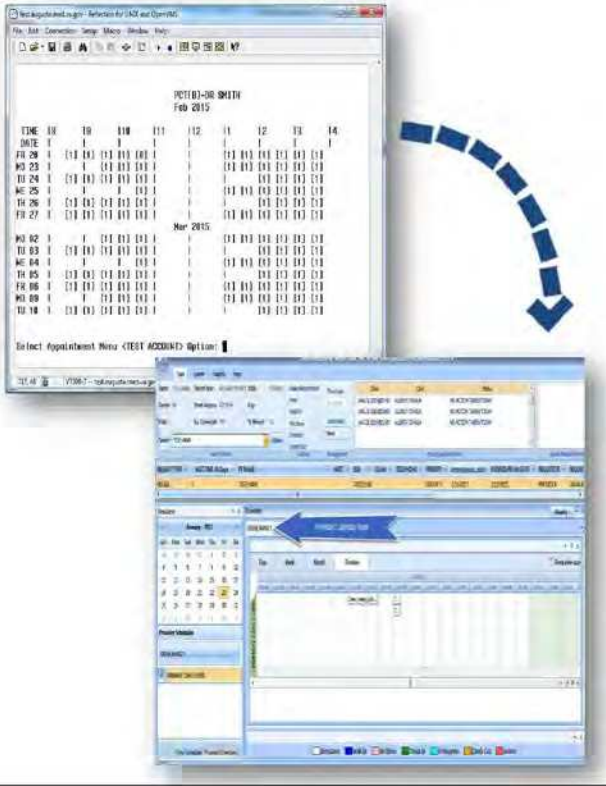
2- Modernize Our Systems

- EMR interoperability and IT modernization
- Infrastructure improvements and streamlining services



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VA Mobile Apps





- **Veteran Appointment Request (VAR)** – Allows Veterans to directly schedule and cancel selected primary care appointments directly through the app
- **Veteran Appointment Usability Study:**
  - ❑ **76%** satisfied with the app
  - ❑ **95%** feel that it has the potential to improve access to care
  - ❑ http://mobile.va.gov/appstore

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3- Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

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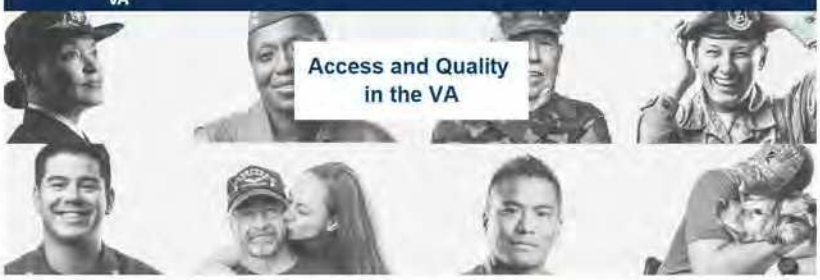
AMERICAN OVERSIGHT

VA



How quickly does my VA see patients?	How satisfied are veterans like me with the timeliness of their care?	How well does my VA's care compare to other hospitals?

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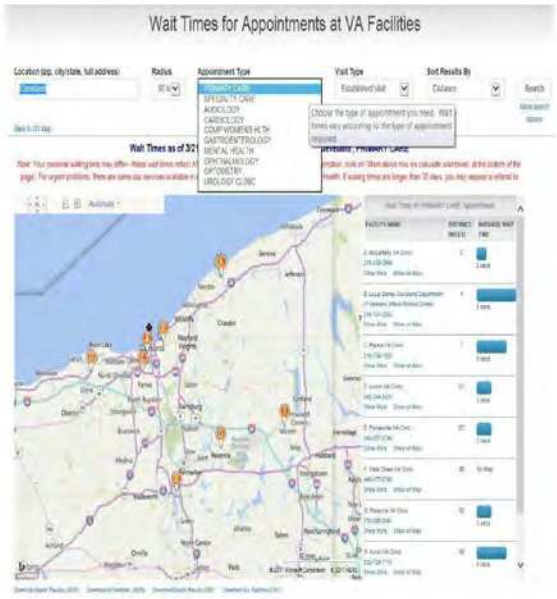
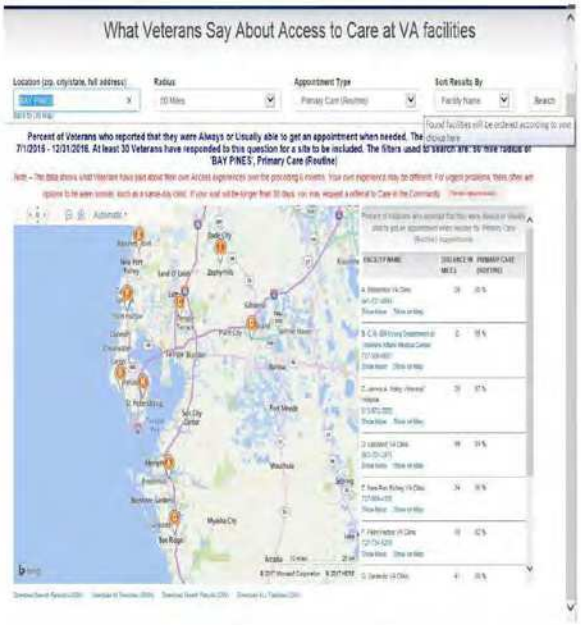
Wait times at local facilities



What Veterans are saying about access



1
5

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4- Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

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World Class Foundational Services











17

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Important Contributions to Society



1
8

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Veterans Day Parade

https://www.youtube.com/watch?v=38pl8hc9aso&feature=youtu.be

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5- Suicide Prevention

GETTING TO ZERO

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Predictive Analytics



- **Suicide**
- **Oncology**
- **PTSD**
- **TBI**

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Center for Compassionate Innovation

To enhance Veterans health and well-being by offering safe and ethical therapies after traditional treatments have not been successful



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VA Research



Barcoding of Medications



Nicotine Patches



First Liver Transplant



8 Lasker Awards



Cardiac Pacemaker



3 Nobel Prizes



Artificial Kidney



CT Scanner

25

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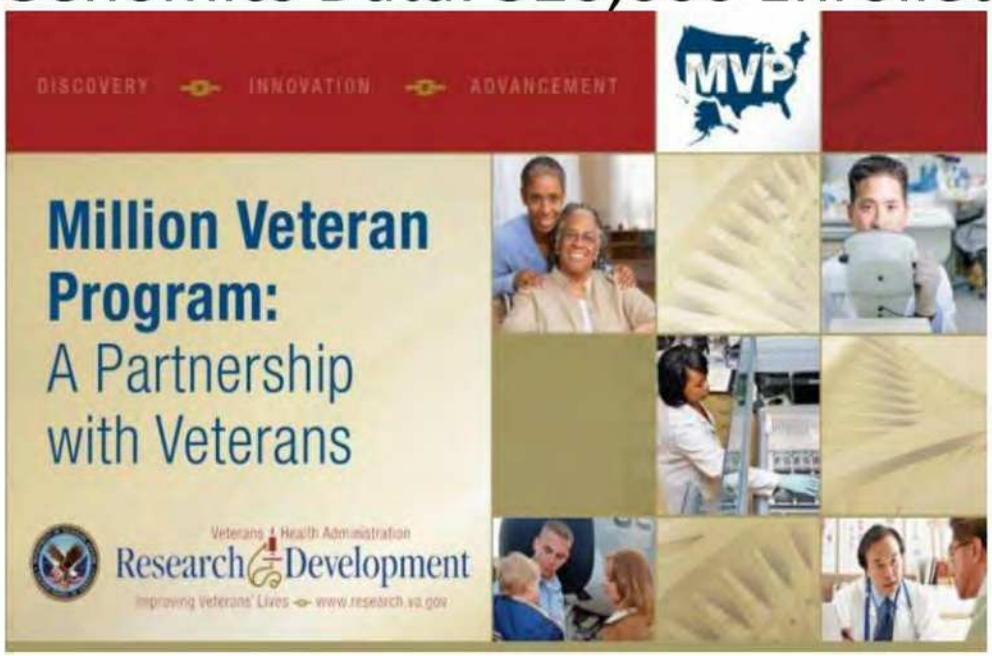
Genomics Data: 520,000 Enrolled



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Taking the Lead in Healthcare Big Data

- Big Data Announcement Slide

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 7:10:02 PM
To: (b) (6) hotmail.com; brucem(b) (6) @mac.com
Subject: Re: Buffalo VA

Thanks Poonam

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: Bruce Moskowitz <(b) (6) mac.com>; David shulkin <drshulkin@aol.com>
Sent: Sun, Apr 16, 2017 1:43 pm
Subject: Re: Buffalo VA

Bruce and David, my team just concluded speaking to Medical Center Director, COS for Asst Sec of IT, the local Administrator on Duty, and the ED with the following facts :

- There are no tickets or reports of any IT issues in the VA Medical Center or Clinics in Buffalo with all systems operating normally
- There are some routine switch replacements occurring in the Buffalo VA with periodic blips in system, but all this is routine, planned with no disruption in patient care services or problems reported
- However, the Erie County Medical Center did take their system down earlier this week because of attempts to infiltrate, presumably by hackers and are slowly brining it back on line.

It is safe to say that everything is operating appropriately at Buffalo VA between the on the ground confirmation and the medical center directors validation at this time.

Thanks Bruce, really appreciate the heads up so that we can fix any issues preemptively.

From: Bruce Moskowitz <(b) (6) mac.com>
Sent: Sunday, April 16, 2017 12:39 PM
To: David shulkin; Poonam Alaigh
Subject: Buffalo VA

Are you aware of the hacking they can't use the computer system?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/16/2017 5:43:06 PM
To: Bruce Moskowitz [(b) (6) mac.com]; David shulkin [drshulkin@aol.com]
Subject: Re: Buffalo VA

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Sent: Sunday, April 16, 2017 12:39 PM
To: David shulkin; Poonam Alaigh
Subject: Buffalo VA

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 4:51:39 PM
To: brucem(b) (6) @mac.com
Subject: Re: Buffalo VA

no not sure what this is about

-----Original Message-----
From: Bruce Moskowitz <(b) (6) mac.com>
To: David shulkin <drshulkin@aol.com>; Poonam Alaigh <(b) (6) hotmail.com>
Sent: Sun, Apr 16, 2017 12:39 pm
Subject: Buffalo VA

Are you aware of the hacking they can't use the computer system?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/16/2017 4:39:15 PM
To: David shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]
Subject: Buffalo VA

Are you aware of the hacking they can't use the computer system?

Sent from my iPhone

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Message

From: Bob McDonald [(b) (6) gmail.com]
Sent: 4/16/2017 8:54:56 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE:

Thanks for your note, David. I wish you all well. Getting the right team in place is the most difficult, most time-consuming, and most important thing to do. I regret it took me so long in every job I have held. Please say hi to everyone for me. Thanks again. Bob

-----Original Message-----
From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Sunday, April 16, 2017 4:16 PM
To: bob mcDonald <(b) (6) mail.com>
Subject:

Bob- just a quick note to say hello and let you know I think of you often.

Scott and I are holding the fort and continuing to build on the progress you made- No doubt your missed but everyone knows that you'd want us to carry on.

There is so much going on and without a full team i am so busy that time rushes by- but i wanted to let you know that i hope you are doing well and hope to see you soon

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/16/2017 8:15:31 PM
To: bob mcDonald [(b) (6) gmail.com]

Bob- just a quick note to say hello and let you know I think of you often.

Scott and I are holding the fort and continuing to build on the progress you made- No doubt your missed but everyone knows that you'd want us to carry on.

There is so much going on and without a full team i am so busy that time rushes by- but i wanted to let you know that i hope you are doing well and hope to see you soon

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 7:30:41 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]
Subject: Fwd: Florida Governor Joins Trump To Sign Veterans Bill At White House – CBS Miami

Clip below

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) gmail.com>
Date: April 19, 2017 at 3:29:06 PM EDT
To: David Shulkin <drshulkin@aol.com>
Subject: Florida Governor Joins Trump To Sign Veterans Bill At White House – CBS Miami

http://miami.cbslocal.com/2017/04/19/florid-governor-trump-sign-veterans-bill-white-house/amp/

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Message

From: [redacted] [redacted]gmail.com]
Sent: 4/19/2017 7:29:06 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Florida Governor Joins Trump To Sign Veterans Bill At White House – CBS Miami

http://miami.cbslocal.com/2017/04/19/florid-governor-trump-sign-veterans-bill-white-house/amp/

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 1:17:25 AM
To: IP [(b) (6)frenchangel59.com]
Subject: Re: RE:

Thanks Ike

Sent from my iPhone

> On Apr 17, 2017, at 8:47 PM, IP <(b) (6)frenchangel59.com> wrote:
>
> David,
>
> We are very happy that the Senator is willing to help.
>
> We definitely can use his help.
>
> We have "fires" in too many locations.
>
> We need all the support we can get.
>
> Please note you copied the wrong Marc.
>
> Please send to Marc Sherman.
> (b) (6) mail.com
>
> Thank you,
> Ike
> -----Original Message-----
> From: David shulkin [mailto:Drshulkin@aol.com]
> Sent: Monday, April 17, 2017 8:10 PM
> To: Ike Perlmutter; Laurie Perlmutter; Bruce Moskowitz; (b) (6)
> Subject:
>
> Not sure if i told you I had a good conversation with Senator Tester - it
> was a great suggestion of all of you to make- he wants to work with us on
> accountability
>
> Bruce- if you get the Annals of internal medicine- i have an article today
> (on line) on Veteran wait times
>
> David
>
> Sent from my iPhone
>

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 12:59:15 AM
To: IP [(b) (6) frenchangel59.com]
CC: David shulkin [Drshulkin@aol.com]
Subject: Re: RE:

Excellent will look at article

Sent from my iPhone

> On Apr 17, 2017, at 8:47 PM, IP <(b) (6) frenchangel59.com> wrote:
>
> David,
>
> We are very happy that the Senator is willing to help.
>
> We definitely can use his help.
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> Ike
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> From: David shulkin [mailto:Drshulkin@aol.com]
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> Subject:
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>
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> (on line) on Veteran wait times
>
> David
>
> Sent from my iPhone
>

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Message

From: IP [(b) (6) frenchangel59.com]
Sent: 4/18/2017 12:47:17 AM
To: 'David shulkin' [Drshulkin@aol.com]
CC: (b) (6) mac.com
Subject: RE:

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(b) (6) mail.com

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Ike
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From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Monday, April 17, 2017 8:10 PM
To: Ike Perlmutter; Laurie Perlmutter; Bruce Moskowitz; (b) (6)
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David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 12:09:59 AM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]; (b) (6) yahoo.com]

Not sure if i told you I had a good conversation with Senator Tester - it was a great suggestion of all of you to make- he wants to work with us on accountability

Bruce- if you get the Annals of internal medicine- i have an article today (on line) on Veteran wait times

David

Sent from my iPhone

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/23/2017 12:34:14 PM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: DPC and other Updates

Thanks

I think just pushing the senate is all we need from Potus

I agree with you comments on the majority bill

I think I agree with your recommendation but I'd like to review it with you in person- maybe we can get the design group together again soon

Sent from my iPad

On Apr 22, 2017, at 7:15 PM, Darin Selnick <(b) (6) @gmail.com> wrote:

> **WH Thursday event**: (b) (6) from DPC called me. He wanted to know for the WH event on Thursday if there was anything specific you wanted the President to say about the Accountability bill stalled in the Senate. They are still firming up his remarks and this is a good opportunity to push again on the Senate bill.
>
> **SVAC draft "Veterans Choice Act of 2017"**: Just a heads up that I received from (b) (6) from McCain a copy of the new red lined version of SVAC majority draft choice legislation. It is terrible and would cost a fortune. Basically veterans can pick any provider in the network when they want, no cost mitigation, VA is primary payer and can only collect from OHI on the back end for non-service connected. Here is a couple of quotes:
>
> "the decision to receive care or services under this section, including the decision to receive care or services from a ~~particular individual or entity~~ **health care provider** specified in subsection (c), shall be at the election of the veteran."
>
> **h) Treatment of Other Health-care Plans.—(1) In any case in which a covered veteran is furnished** care or services under this section ~~with an individual or entity specified in subsection (c)(5) if the individual or entity meets criteria established by the Secretary for purposes of this section.~~ **for a non-service-connected disability described in subsection (a)(2) of section 1729 of this title, the Secretary may recover or collect reasonable charges for such care or services from a health-care plan described in paragraph (3) in accordance with such section.**
>
> I expect this to be rejected immediately from conservative Senators like Lee and in the House like Dr. Roe. CBO score will be huge. Staff from McCain and Moran have indicated this plan is just a starting point. I will be meeting with them on Friday to discuss.
>
> **Choice 2.0. recommendation:** In order to maximize our revenue at the VAMC and minimize the payout in Choice 2.0., we should be more like the private sector and follow what the independent assessment recommended.
>
> - All enrolled veterans must be required to declare their OHI and we should check and update our records when they see their providers. All staff should be required to ask the OHI question. To make Choice affordable, VA needs to collect from the 80% OHI as much as possible at the VAMC and for Community Care have OHI pay as much as possible upfront to reduce our spend.
>
> - All VAMC providers should be required to more narrowly and correctly identify all treatments that are service-connected. Poonam gives the example how she just checks off routinely service

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connected. That practice must stop if in 2.0. we are going to collect all we can from OHI. If a private sector provider like what I used to work for had that restriction, they would be making sure they were collecting every dollar they could, and so should we. Part of changing the culture to a private sector mentality.

Darin

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/22/2017 11:15:48 PM
To: David shulkin [Drshulkin@aol.com]
Subject: DPC and other Updates

WH Thursday event: (b) (6) from DPC called me. He wanted to know for the WH event on Thursday if there was anything specific you wanted the President to say about the Accountability bill stalled in the Senate. They are still firming up his remarks and this is a good opportunity to push again on the Senate bill.

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h) Treatment of Other Health-care Plans.—(1) In any case in which a covered veteran is furnished care or services under this section ~~with an individual or entity specified in subsection (c)(5) if the individual or entity meets criteria established by the Secretary for purposes of this section.~~ **for a non-service-connected disability described in subsection (a)(2) of section 1729 of this title, the Secretary may recover or collect reasonable charges for such care or services from a health-care plan described in paragraph (3) in accordance with such section.**

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Darin

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 11:56:13 PM
To: Jennifer Lee [(b) (6) gmail.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]

Lets discuss the telehealth eo in the am

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 11:34:38 AM
To: (b) (6) [(b) (6) va.gov]
Subject: Fwd: Today's JAMA article on VA hospitals outperforming non VA hospitals

Please print article

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) hotmail.com>
> **Date:** April 18, 2017 at 5:26:55 AM EDT
> **To:** Marc Sherman <(b) (6) gmail.com>, Laurie Perlmutter <(b) (6) gmail.com>, Ike Perlmutter <(b) (6) frenchangel59.com>, "brucem(b) (6) @mac.com" <brucem(b) (6) @mac.com>
> **Cc:** David Shulkin <drshulkin@aol.com>
> **Subject: Today's JAMA article on VA hospitals outperforming non VA hospitals**
>
> http://www.beckershospitalreview.com/quality/va-hospitals-outperform-non-va-hospitals-on-patient-outcome-measures.html
>
> Ideas for communicating this?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 11:24:20 AM
To: Marc Sherman [(b) (6) gmail.com]
CC: David shulkin [Drshulkin@aol.com]; L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Today's JAMA article on VA hospitals outperforming non VA hospitals

The way data is collected raised every red flag among my colleagues and even discussed in the article. It is easy to show how easily the data can be manipulated and proved to be a false outcome. However the VA does do somethings in the article that is better than the whole sum of the private sector. I am afraid that will get lost in the rebuttal. There are articles like the VA telemedicine for mental health study that is research excellence that had no coverage and of great importance.

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 18, 2017, at 7:17 AM, Marc Sherman <(b) (6) gmail.com> wrote:

> But it is also a tool of great value. We should discuss live.
>
> Marc Sherman
> (202) 758-(b) (6)
>
> On Apr 18, 2017 7:09 AM, "David shulkin" <Drshulkin@aol.com> wrote:
> Ok thanks Bruce- we will be cautious
>
> Sent from my iPhone
>
> On Apr 18, 2017, at 6:47 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> > I would be concerned about communicating this I read the full article and letter. Both point out the data may be incorrect for a variety of reasons. Also the full article points to the many deficiencies.
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.
> >
> > On Apr 18, 2017, at 5:26 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
> >
> > > http://www.beckershospitalreview.com/quality/va-hospitals-outperform-non-va-hospitals-on-patient-outcome-measures.html
> > >
> > > Ideas for communicating this?
> > >
> > > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 11:04:54 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; Marc Sherman [(b) (6) gmail.com]; Laurie Perlmutter [(b) (6) gmail.com]; Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re: Today's JAMA article on VA hospitals outperforming non VA hospitals

Ok thanks Bruce- we will be cautious

Sent from my iPhone

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> >
> > Ideas for communicating this?
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 10:47:42 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: Marc Sherman [(b) (6) gmail.com]; Laurie Perlmutter [(b) (6) gmail.com]; Ike Perlmutter [(b) (6) frenchangel59.com]; David Shulkin [drshulkin@aol.com]
Subject: Re: Today's JAMA article on VA hospitals outperforming non VA hospitals

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Sent from my iPad
Bruce Moskowitz M.D.

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>
> Ideas for communicating this?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/18/2017 9:26:55 AM
To: Marc Sherman [(b) (6) gmail.com]; Laurie Perlmutter [(b) (6) gmail.com]; Ike Perlmutter [(b) (6) frenchangel59.com]; (b) (6) mac.com
CC: David Shulkin [drshulkin@aol.com]
Subject: Today's JAMA article on VA hospitals outperforming non VA hospitals

http://www.beckershospitalreview.com/quality/va-hospitals-outperform-non-va-hospitals-on-patient-outcome-measures.html

Ideas for communicating this?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 5/21/2017 8:16:30 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Ok

On May 21, 2017 4:12 PM, "David shulkin" <Drshulkin@aol.com> wrote:

> For tommorow with [redacted] lets add
>
> Telehealth comms plans
>
> Other active Executive orders -
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/21/2017 8:12:27 PM
To: (b) (6) [(b) (6) gmail.com]

For tommorow with (b) (6) lets add

Telehealth comms plans

Other active Executive orders -

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 8:35:56 PM
To: Jennifer Lee [(b) (6) gmail.com]

Younshould get the myva meetings on yiur calander

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 4:19:21 PM
To: (b) (6) gmail.com
Subject: print please choice redesign version 2
Attachments: choicedesign.pptx

AMERICAN OVERSIGHT

Clinical System Design



Clinical Analytics and Choice Eligibility Board

Clinical Groupings with Poor Performance

VA Does Not Offer Service

Clinical Groupings with Good or Superior Performance

Foundational Services

Full Choice

VA Care/Community Care

Whole Health Model of Care Coordination, Telehealth, Caregivers, Homelessness

AMERICAN OVERSIGHT

Clinical System Design



VA TRIAGE SYSTEM

Urgent Issues

VA Does Not Offer Service

Chronic Care and Non Acute Issues

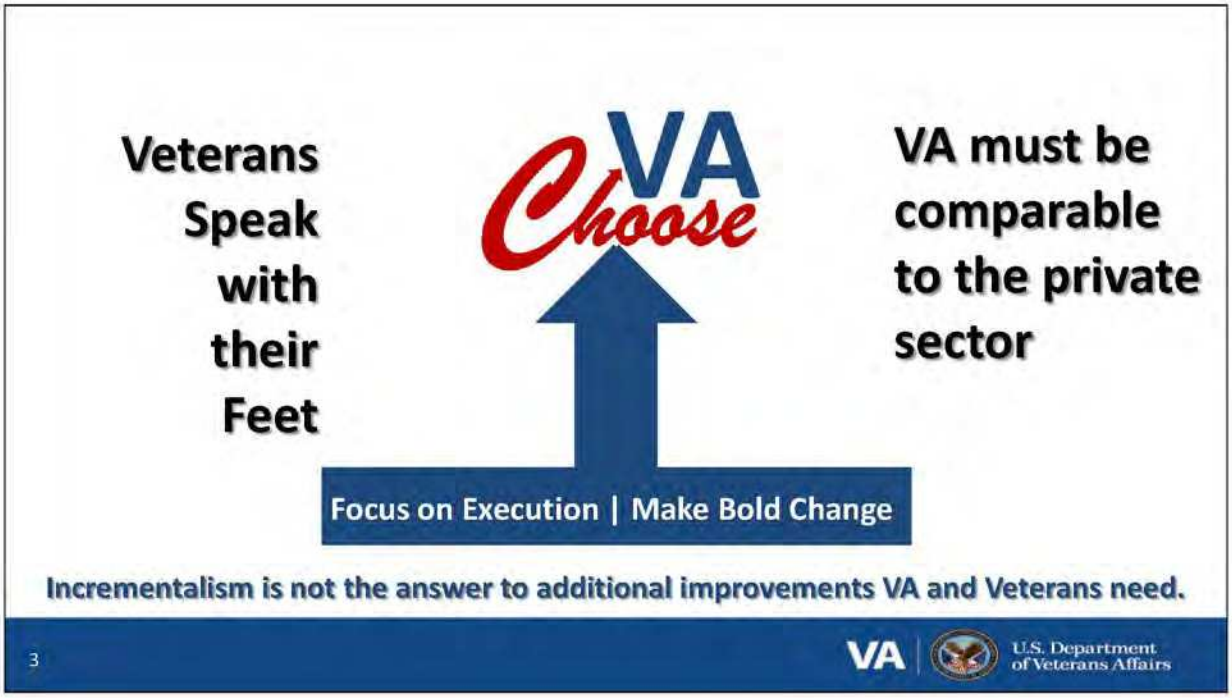
Foundational Services

Full Access to Community

VA Care/Community Care

Whole Health Model of Care Coordination, Telehealth, Caregivers, Homelessness

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Building a Seamless (Integrated) Network



Choice 2.0 is a ***3-Phased*** approach over a ***5-year*** horizon. Through *modernization* and continued *integration* with the VA and Community Care providers are able to deliver more health options to better serve our Veterans.

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 5/12/2017 9:31:22 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

On a call. Will call you when finished.

Marc Sherman
(202) 758-(b) (6)

On May 12, 2017 4:47 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Marc- what is your cell phone?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 5/12/2017 9:00:13 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

See below

Marc Sherman
(202) 758-(b) (6)

On May 12, 2017 4:47 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Marc- what is your cell phone?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/12/2017 8:47:29 PM
To: (b) (6) gmail.com

Marc- what is your cell phone?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/20/2017 12:59:28 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Ending the Opioid Crisis fyi newt

Just fyi

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) speakergingrich.com>
> **Date:** April 19, 2017 at 8:42:35 PM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Ending the Opioid Crisis fyi newt**
>
> I agree and will add to the paper newt
>
> Sent from my iPhone
>
> > On Apr 19, 2017, at 7:29 PM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > Newt- this is very effective and well stated.
> >
> > Pain is such a big issue in VA- what about making VA a fast tract FDA site to get help to veterans faster? We dont want to be experimenting on veterans but why not let veterans have the choice to receive these breakthroughs first?
> >
> > Also VA researchers could join your list of those than can help speed further discoveries.
> >
> > Great job- keep it up!
> >
> > David
> >
> > Sent from my iPhone
> >
> > > On Apr 19, 2017, at 4:52 PM, (b) (6) <(b) (6) speakergingrich.com> wrote:

AMERICAN OVERSIGHT

<Ending the Opioid Crisis.docx>

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/28/2017 1:04:45 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; mbs(b) (6)@gmail.com; lper(b) (6)@gmail.com; IP [(b) (6) frenchangel59.com]
Subject: Re: Baltimore meeting for inventory

Got it

Sent from my iPhone

> On Apr 27, 2017, at 8:37 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Ike wants to be sure (b) (6) is aware and provides the ability to protect any intellectual capital that comes out of effort.
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/28/2017 12:37:03 AM
To: David shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]
CC: (b) (6) hotmail.com; mbs(b) (6) @gmail.com; lper(b) (6) @gmail.com; IP [(b) (6) frenchangel59.com]; drshulkin@aol.com
Subject: Baltimore meeting for inventory

Ike wants to be sure (b) (6) is aware and provides the ability to protect any intellectual capital that comes out of effort.

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/24/2017 3:11:14 PM
To: (b) (6) [(b) (6) gmail.com]

Can you get me tbe blue water navy paper they prepared for me?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/1/2017 4:40:00 PM
To: Bruce Moskowitz [(b) (6) mac.com]

The ENT research looks good- we will follow

On the tinnitus test should we followup
With you or Dr (b) (6) ?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/19/2017 11:40:16 PM
To: Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]
CC: Marc Sherman [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]

This is the real clip from today

https://m.youtube.com/watch?v=AufMXIGtr-Q

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 9:35:29 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Star ratings

Aware I spent the last three hours understanding what they did and it does not get us to where we need to be. They were looking at metrics that would not pick up supply and staffing problems etc. If you need full report I have it. From all that I read if we outsource some high priority things like the inventory we will solve many problems.
Staffing is getting to be impossible in the private sector.
Telemedicine will solve mental health staffing problems and I am busy looking at platforms the medical centers are using. I am meeting with (b) (6) tonight who does your public private partnerships and was on J&J call.
Perhaps a committee that looked at what can be outsourced or brought in from the private sector would help.

Sent from my iPhone

> On Apr 18, 2017, at 5:21 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Bruce- all facilities are jcaho approved and we have full access to all of their reports and findings
>
> Sent from my iPhone
>
>> On Apr 18, 2017, at 3:38 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>
>> Yes reviewed it it really does not get us to where we want to see if quality measures are being enacted and followed.
>>
>> Sent from my iPad
>> Bruce Moskowitz M.D.
>>
>>> On Apr 18, 2017, at 2:47 PM, David shulkin <Drshulkin@aol.com> wrote:
>>>
>>> They already gave this
>>>
>>> Sent from my iPhone
>>>
>>>> On Apr 18, 2017, at 1:59 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>>>
>>>> Is there any reason why we can not have every VA obtain Joint
>>>> Commission of Accreditation status?
>>>>
>>>> Sent from my iPad
>>>> Bruce Moskowitz M.D.
>>>>
>>>>> On Apr 18, 2017, at 1:52 PM, David shulkin <Drshulkin@aol.com> wrote:
>>>>>
>>>>> The date that we will have comparable quality data with the private sector is July 1st.
>>>>>
>>>>> We have to rely upon Medicare to do this as its their data set. We are calling Medicare to see if they can accelerate this.
>>>>>
>>>>> David
>>>>>
>>>>> Sent from my iPhone
>>>
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 9:21:24 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Star ratings

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Sent from my iPhone

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>>>>
>>>> David
>>>>
>>>> Sent from my iPhone
>>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 7:38:31 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re: Star ratings

Yes reviewed it it really does not get us to where we want to see if quality measures are being enacted and followed.

Sent from my iPad
Bruce Moskowitz M.D.

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>>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 6:47:36 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re: Star ratings

They already gave this

Sent from my iPhone

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AMERICAN OVERSIGHT

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From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/18/2017 5:59:21 PM
To: David shulkin [Drshulkin@aol.com]
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> David
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> Sent from my iPhone

AMERICAN OVERSIGHT

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To: Ike Perlmutter [(b) (6)frenchangel59.com]
CC: Bruce Moskowitz [(b) (6) mac.com]
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David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/20/2017 10:48:46 AM
To: Poonam Alaigh [(b) (6) hotmail.com]; (b) (6) [(b) (6) yahoo.com]
Subject: Great picture

https://www.healthdatamanagement.com/news/va-tool-provides-patient-wait-times-quality-of-care-data

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/19/2017 12:45:01 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]; L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]
Subject: Re: (b) (6)

There is no equal!!!

Marc Sherman
(202) 758-(b) (6)

On Apr 18, 2017 8:05 PM, "Bruce Moskowitz" <(b) (6) mac.com> wrote:

> I am at dinner with an equal to David and Poonam. She has been with the VA 15 years and has done amazing VA partnerships with IBM, Bristol Myers and is accomplishing in real time many of the initiatives we are working on. Fantastically bright like David and Poonam.
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/16/2017 4:04:40 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

I'll share there matrix they say it's a lot of events in May more than they have ever seen. Will print there working sheet for you to see what they are working on. Some of it the items were not needed.
On Sun, Apr 16, 2017 at 9:20 AM David Shulkin <drshulkin@aol.com> wrote:

What could they possibly be doing? I don't get what they are doing

-----Original Message-----

From: [redacted] <[redacted]gmail.com>

To: David Shulkin <drshulkin@aol.com>

Sent: Sat, Apr 15, 2017 7:20 pm

Subject: Re:

Yes. I told the speechwriters I would work on bc they are overwhelmed.

AMERICAN OVERSIGHT

On Sat, Apr 15, 2017 at 6:48 PM David Shulkin <drshulkin@aol.com> wrote:

Here are some slides for SMAG- we may need to fix them up

--

Sent from Gmail Mobile

--
Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 1:20:07 PM
To: (b) (6) gmail.com
Subject: Re:

What could they possibly be doing? I don't get what they are doing

-----Original Message-----
From: (b) (6) <(b) (6) gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Apr 15, 2017 7:20 pm
Subject: Re:

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--
Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/15/2017 11:20:14 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

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Here are some slides for SMAG- we may need to fix them up
--
Sent from Gmail Mobile

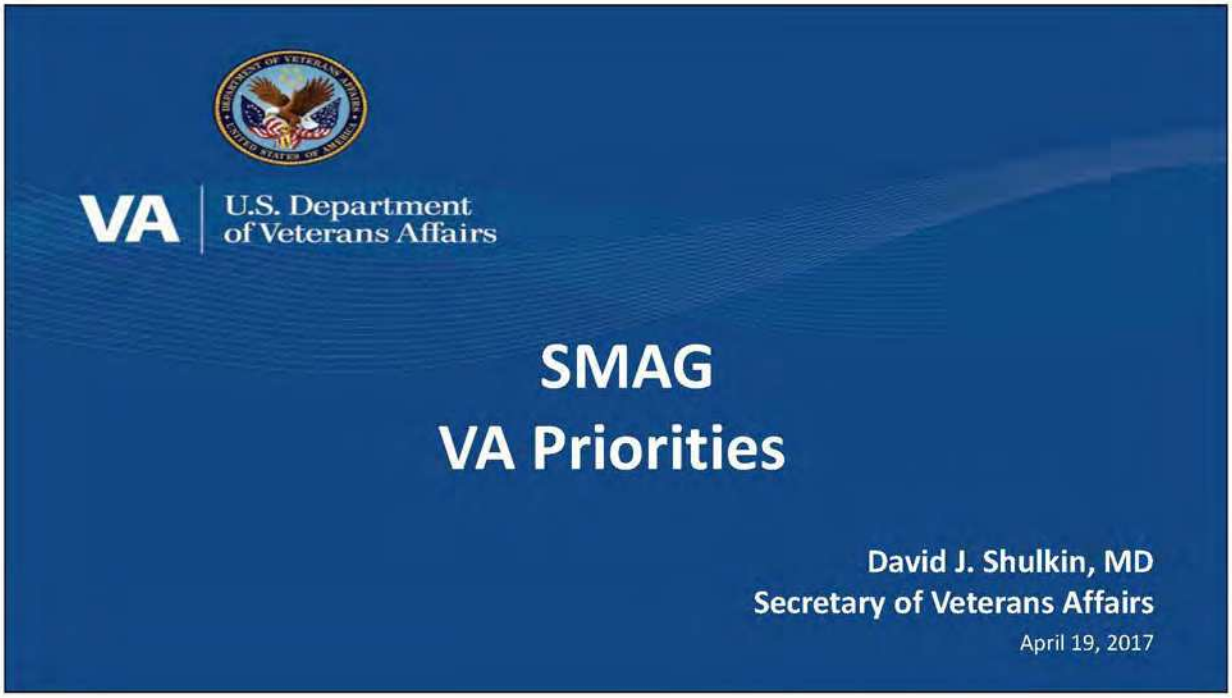
AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/15/2017 10:48:34 PM
To: (b) (6) [redacted]gmail.com
Attachments: smag2017.pptx

Here are some slides for SMAG- we may need to fix them up

AMERICAN OVERSIGHT



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United's Response



AMERICAN OVERSIGHT

Events at the DC VA



AMERICAN OVERSIGHT

We need Transformation Change and Actions



VA U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

VA's 5 Priorities

1. Greater Choice for Veterans
2. Modernize our Systems
3. Focus Resources More Efficiently
4. Improve Timeliness of Services
5. Suicide Prevention



VA U.S. Department of Veterans Affairs

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1. Greater Choice for Veterans

- Redesign the 40/30 Rule to use clinical criteria for veteran choice
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Clinical System Design



Clinical Analytics and Choice Eligibility Board

Clinical Groupings with Poor Performance

VA Does Not Offer Service

Clinical Groupings with Good or Superior Performance

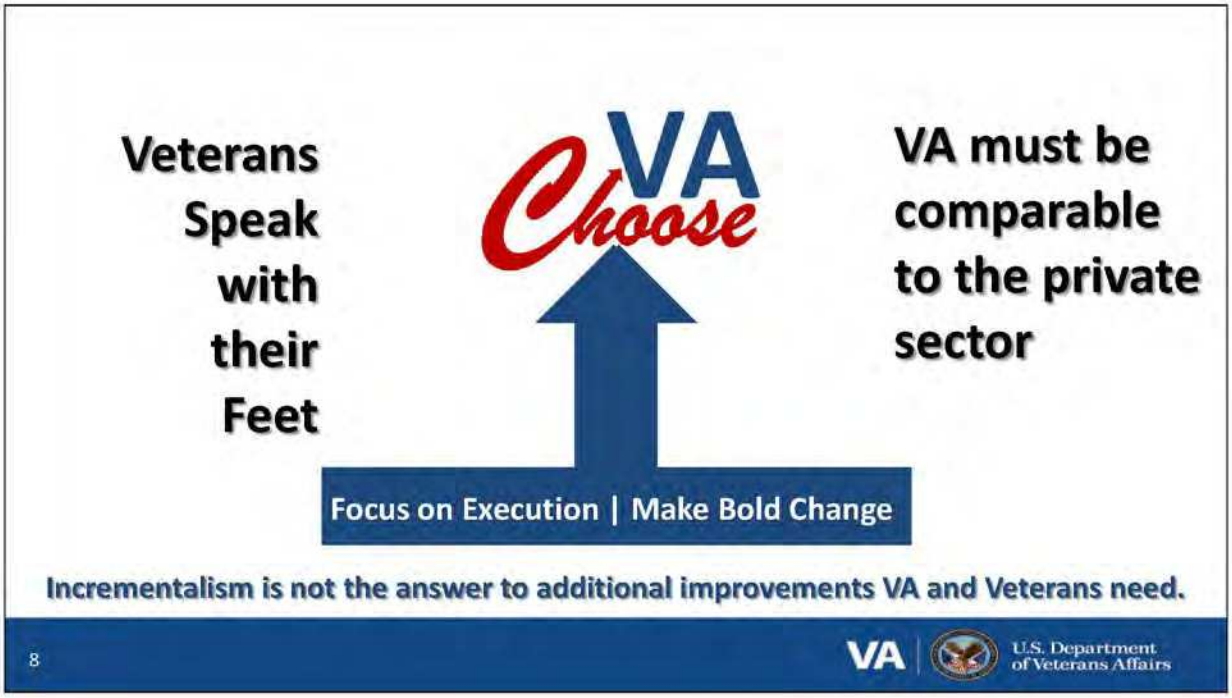
Foundational Services

Full Choice

VA Care/Community Care

Whole Health Model of Care Coordination, Telehealth, Caregivers, Homelessness

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Building a Seamless (Integrated) Network



Choice 2.0 is a ***3-Phased*** approach over a ***5-year*** horizon. Through *modernization* and continued *integration* with the VA and Community Care providers are able to deliver more health options to better serve our Veterans.

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

2- Modernize Our Systems

- Infrastructure improvements and streamlining services
- EMR interoperability and IT modernization

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Infrastructure Improvements



Officers' Quarters
Fort Thomas, KY
Circa 1895



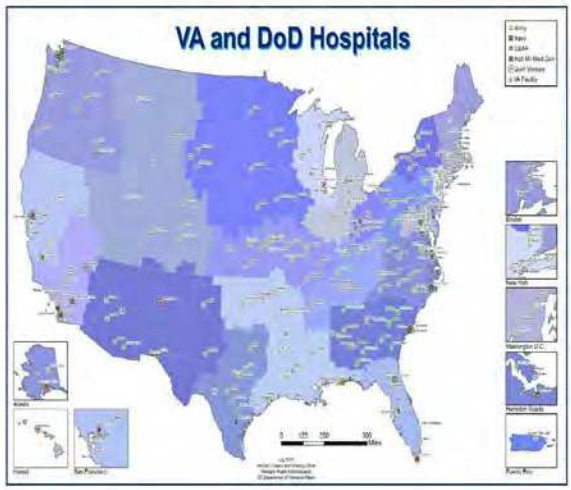
Gas Station
Minneapolis, MN
1932



Palo Alto VAMC
2017

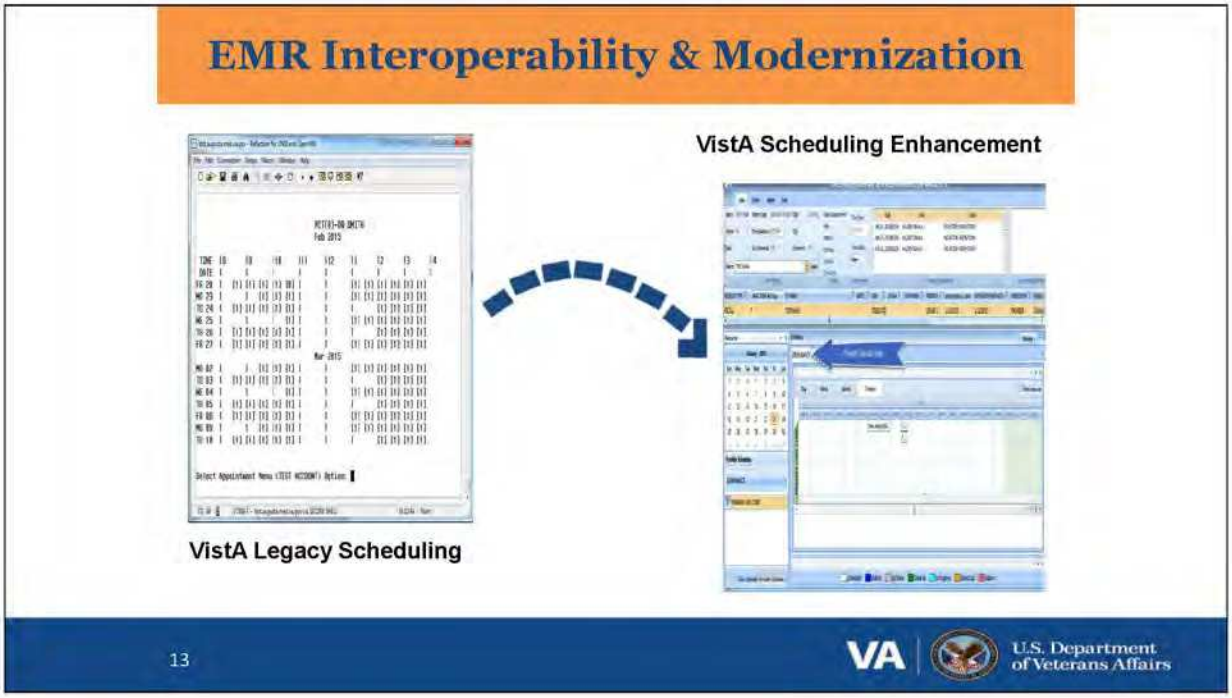
AMERICAN OVERSIGHT

VA/DoD/Federal Coordination



VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT



The point here is VistA was outdated (left), so we've made some improvements (right), but what we really need is a new system that's fully interoperable with what our partnering providers are already using.

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3. Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

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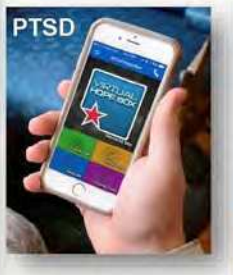
World Class Foundational Services











VA U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Accountability Legislation



Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Direct Hire for Medical Center Directors and Network Directors	Ability to fully utilize our relocation, recruitment, and retention awards	Authority to reccoop relocation expenses authorized through fraud of malfeasance.	Increased **protections for whistleblowers** .

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

4. Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

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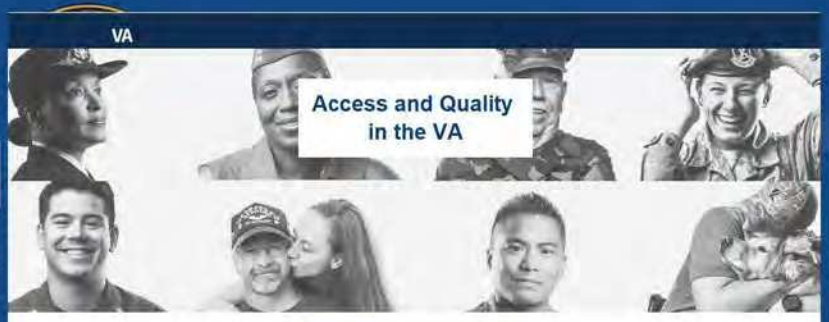
VA



How quickly does my VA see patients?

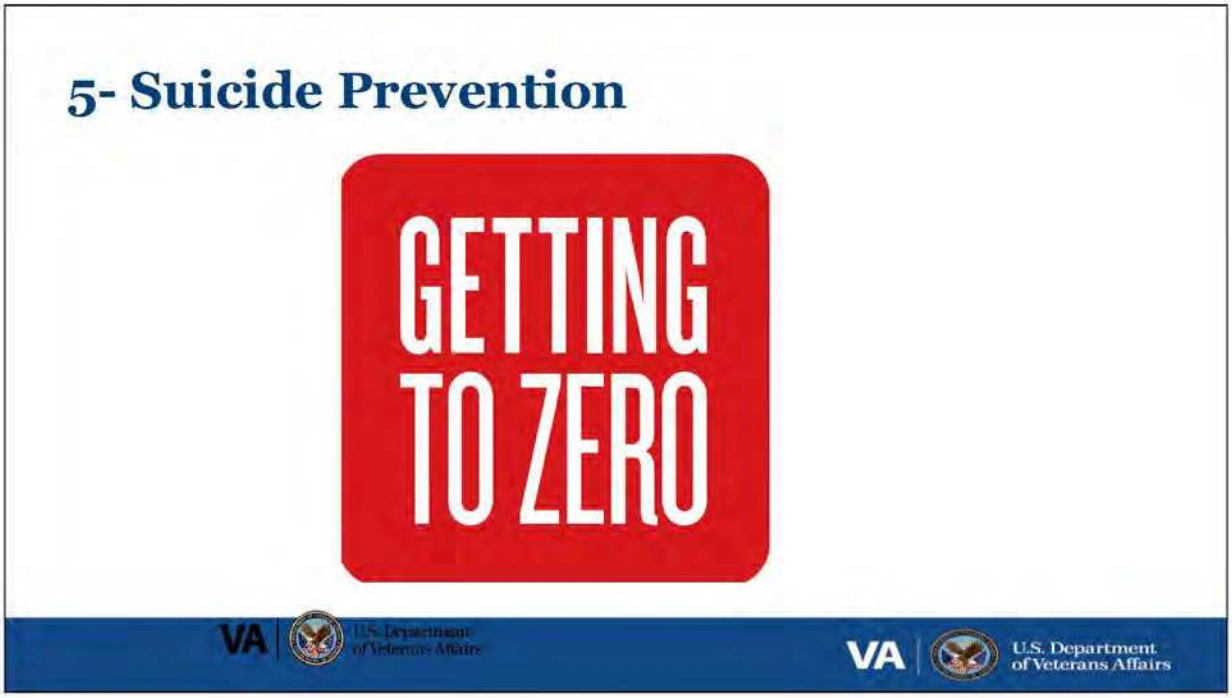
How satisfied are veterans like me with the timeliness of their care?

How well does my VA's care compare to other hospitals?

VA Pre-Decisional

AMERICAN OVERSIGHT

5- Suicide Prevention



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Suicide Prevention



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The video will play as soon as you cue the next slide.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 10:13:44 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Star ratings

Sent from my iPhone

Begin forwarded message:

From: "IP" <(b) (6) frenchangel59.com>
Date: April 18, 2017 at 1:58:33 PM EDT
To: "'David shulkin'" <Drshulkin@aol.com>
Cc: "'Bruce Moskowitz'" <(b) (6) mac.com>
Subject: RE: Star ratings

Can we please do the top 30 right away? Thank you.

-----Original Message-----
From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Tuesday, April 18, 2017 1:52 PM
To: Ike Perlmutter
Cc: Bruce Moskowitz
Subject: Star ratings

The date that we will have comparable quality data with the private sector is July 1st.

We have to rely upon Medicare to do this as its their data set. We are calling Medicare to see if they can accelerate this.

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 6:49:37 PM
To: IP [(b) (6)frenchangel59.com]
CC: Bruce Moskowitz [(b) (6) mac.com]
BCC: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Star ratings

The problem is that we need the data on the other hospitals from Medicare- we are pushing them to give us this faster than July 1

We are working on another way to get this sooner- i didnt want to commit to this until I know we can deliver- but we are trying

Sent from my iPhone

> On Apr 18, 2017, at 1:58 PM, IP <(b) (6)frenchangel59.com> wrote:
>
> Can we please do the top 30 right away? Thank you.
>
> -----Original Message-----
> From: David shulkin [mailto:Drshulkin@aol.com]
> Sent: Tuesday, April 18, 2017 1:52 PM
> To: Ike Perlmutter
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> calling Medicare to see if they can accelerate this.
>
> David
>
> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/18/2017 5:58:33 PM
To: 'David shulkin' [Drshulkin@aol.com]
CC: 'Bruce Moskowitz' [(b) (6) mac.com]
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David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/26/2017 12:01:48 PM
To: Poonam Alaigh [(b) (6) hotmail.com]

(b) (6) will come

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/28/2017 8:04:38 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: David Shulkin [drshulkin@aol.com]; (b) (6) aol.com
Subject: Re: Baltimore meeting

Thank you.

Sent from my iPad
Bruce Moskowitz M.D.

> On Apr 28, 2017, at 4:00 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Just spoke to my internal team and May 15 is confirmed on our end. We have the wheels in motion already- you can let your team know. (b) (6) will help coordinate the effort on my behalf here. The meeting will be at the Baltimore Medical Center. Details to follow- thanks a ton
>
> Sent from my iPhone
>
>> On Apr 28, 2017, at 2:25 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>
>> Our contingent needs to know if May 15 works especially the large group traveling form Kaiser. I would like to get back to them this weekend if possible. Thank you
>>
>> Sent from my iPad
>> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/28/2017 6:34:52 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: Baltimore meeting

Let's discuss

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** April 28, 2017 at 2:25:22 PM EDT
> **To:** Poonam Alaigh <(b) (6) hotmail.com>
> **Subject: Baltimore meeting**
>
> Our contingent needs to know if May 15 works especially the large group traveling form Kaiser. I would like to get back to them this weekend if possible. Thank you
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/19/2017 11:36:07 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Checking In

Let's look at the organization and the size of their meetings first

Sent from my iPad

On Apr 19, 2017, at 7:27 PM, (b) (6) <(b) (6) gmail.com> wrote:

> Do you want to do this? I'll look at the date tmrw
> On Wed, Apr 19, 2017 at 7:26 PM David shulkin <Drshulkin@aol.com> wrote:
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) msn.com>
> **Date:** April 19, 2017 at 12:44:14 PM EDT
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Checking In**
>
> David, I do hope you are addressing the challenges of your position with your usual energy and enthusiasm and drive to attain palpable results. Need to ask how did your meeting today with Mr. Trump go?
>
> The Hospital Planning & Marketing Society of NJ wants to present you with an award and have you deliver the key note address at their December 1 Annual Meeting in Princeton.
>
> You suggested to reach out and check in when things "settled down". Are we there yet?
>
> Hope to hear back when you have a chance to take a breath.
>
> Best regards
>
> (b) (6)
>
> --
> Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/19/2017 11:27:07 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Checking In

Do you want to do this? I'll look at the date tmrw
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Sent from my iPhone

Begin forwarded message:

> **From:** [redacted] <[redacted]msn.com>
> **Date:** April 19, 2017 at 12:44:14 PM EDT
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Checking In**
>
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>
> Hope to hear back when you have a chance to take a breath.
>
> Best regards
>
> [redacted]

—
Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 11:26:16 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: Checking In

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) msn.com>
Date: April 19, 2017 at 12:44:14 PM EDT
To: David Shulkin <drshulkin@aol.com>
Subject: Checking In

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Best regards

(b) (6)

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/22/2017 3:47:14 PM
To: IP [(b) (6) frenchangel59.com]; brucem(b) (6) @mac.com; mbs(b) (6) @gmail.com; David shulkin [drshulkin@aol.com]
CC: lper(b) (6) @gmail.com
Subject: Re: Remarks by President Trump at Signing of S. 544, The Veterans Choice Program Extension and Improvement Act

Thanks for keeping us in the loop. We are in the meantime working with a SWAT team to make sure there are no additional vulnerabilities around patient safety related to the inventory management system especially since there has been a recent transition of the software for the system

Hopefully we will meet next week and can catch up some more. Bruce is arranging for us to discuss with Hopkins best practices simultaneously. It would be great if you can send along some good leads for a Chief Logistics Officer located here in DC to be part of our team. If we meet with the Big Five this week, I will be sure to address with them too.

Ike, I cant thank you enough for your guidance. David and I have been talking constantly to make sure with can assemble the right and trusted team in the VA around us.

Laurie and team, looking forward to spending some quality time soon, and possibly this coming week. Also, a gentle reminder to bring me a signed copy of Ike's book.

Thanks

From: IP <(b) (6) frenchangel59.com>
Sent: Thursday, April 20, 2017 10:53 AM
To: brucem(b) (6) @mac.com; mbs(b) (6) @gmail.com; Poonam Alaigh; David shulkin
Cc: lper(b) (6) @gmail.com
Subject: FW: Remarks by President Trump at Signing of S. 544, The Veterans Choice Program Extension and Improvement Act

FYI

From: IP [mailto(b) (6) frenchangel59.com]
Sent: Thursday, April 20, 2017 10:38 AM
To: (b) (6) who.eop.gov; (b) (6) who.eop.gov; (b) (6) who.eop.gov
Cc: (b) (6) gmail.com
Subject: Remarks by President Trump at Signing of S. 544, The Veterans Choice Program Extension and Improvement Act

Jared, (b) (6) and (b) (6)

AMERICAN OVERSIGHT

First, thank you so much for everything you have done and are doing to enhance the efforts to transform Veterans Affairs. Your contributions are so critical to its success.

On December 27, 2016, a number of us had a meeting with the then President Elect and presented to him a plan to transform the VA for our deserving Veterans. Step one of that plan was to extend, and then to enhance, the Veterans Choice Program. Well, yesterday, when the President signed the extension of the Choice Act, we entered the passageway toward making that plan a reality . And, as the media noted, the bigger changes will come this fall when a "Choice 2.0" revamp of the program is unveiled to allow more outside care options.

The procurement issue for the EHR contract is very closely tied to the success of the Choice Program and especially Choice 2.0. That needs to be solved without delay if we plan to climb any further up the hill. That is the very kind of impediment on which we need your laser focus and your continued and swift assistance and resolution. What are your thoughts on timing to get that solved?

While yesterday's accomplishments are a pivotal achievement; in reality, we are just at the beginning of a long uphill climb. And for that climb your help and focus on the VA is more important than ever. I hope we can count on you to keep that focus and sense of urgency toward our shared goal of a transformed VA.

Ike

https://m.youtube.com/watch?v=AufMXIGtr-Q



Trump Signs Veterans Health Choice Program Extension - Full Ceremony And Remarks

m.youtube.com

President Donald Trump signed a bill Wednesday to temporarily extend a program that lets some veterans seek medical care in the private sector, part of an ef...

http://www.militarytimes.com/articles/trump-va-reform-veterans-affairs-choice-card

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Trump extends vets' access to privatized health care

www.militarytimes.com

The Choice Card program allows vets to seek medical care outside VA facilities.

http://www.washingtontimes.com/news/2017/apr/19/donald-trump-signs-extension-veterans-choice-healt/

http://abcnews.go.com/Health/wireStory/trump-extends-private-sector-health-care-program-vets-46887778



Trump extends private-sector health care program for vets

abcnews.go.com

President Donald Trump signed a bill Wednesday to temporarily extend a program that lets some veterans seek medical care in the private sector, part of

AMERICAN OVERSIGHT

an effort by the president to deliver on a campaign promise. The extension will give Veterans Affairs Secretary David Shulkin time to...

From: White House Press Office <whitehouse-noreply@messages.whitehouse.gov>
Date: April 19, 2017 at 1:33:08 PM EDT
Subject: Remarks by President Trump at Signing of S. 544, The Veterans Choice Program Extension and Improvement Act
Reply-To: <whitehouse-noreply@messages.whitehouse.gov>

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 19, 2017

REMARKS BY PRESIDENT TRUMP

AT SIGNING OF S. 544, THE VETERANS CHOICE PROGRAM EXTENSION AND IMPROVEMENT ACT

Roosevelt Room

AMERICAN OVERSIGHT

11:32 A.M. EDT

THE PRESIDENT: Good morning. We're honored to join and be joined today by some absolutely tremendous people and great veterans. Thanks, as well -- and I have to thank them dearly -- but as well to Representative Phil Roe. Where is he? What a job you've done. And all the members of Congress who worked on the bill that we're about to sign. Such an important bill.

I especially want to thank Senator John McCain and Senator Johnny Isaacson. They have been incredible in working with us. Let me also welcome my good friend, Florida Governor Rick Scott, a Navy veteran who's here with us to represent more than a million veterans from the state of Florida. We're also joined by the leaders of a number of veterans groups. I want to thank all of them for being here and all of the tremendous and important work that they do. We would not be here if it weren't for them, I can tell you that.

Finally, I want to thank our Secretary of the VA, David Shulkin, who, by the way, was approved with a vote of 100 to nothing. That's shocking, right? (Laughter.) One hundred to nothing, really. Now, you wouldn't be getting 100 to nothing. (Laughter.)

We met earlier today in the Oval Office, and Secretary Shulkin updated me on the massive and chronic challenge he inherited at the VA, but also the great progress that he is making. He's got a group of people that are phenomenal at the VA. It's one of my most important things. I've been telling all of our friends at speeches and rallies for two years about the VA, how we're going to turn it around. And we're doing that.

And, actually, next week, on Thursday at 2 o'clock, we're going to have a news conference with David and some others to tell you about all of the tremendous things that are happening at the VA and what we've done in terms of progress and achievement.

The veterans have poured out their sweat and blood and tears for this country for so long, and it's time that they're recognized, and it's time that we now take care of them, and take care of them properly.

That's why I'm pleased today to sign into law the Veterans Choice Program Improvement Act. So this is called the Choice Program Improvement Act. It speaks for itself. This bill will extend and improve the Veterans Choice Program so that more veterans can see the doctor of their choice -- you got it? The doctor of their choice -- and don't have to wait and travel long distances for VA care. Some people have to travel five

AMERICAN OVERSIGHT

hours, eight hours, and they'll have to do it on a weekly basis, and even worse than that. It's not going to happen anymore.

This new law is a good start, but there is still much work to do. We will fight each and every day to deliver the long-awaited reforms our veterans deserve, and to protect those who have so courageously protected each and every one of us.

So we've made a lot of strides for the veterans. These are, like, the most incredible people we have in our country as far as I'm concerned, and they have not been taken care of properly.

I want to thank David. You've done an incredible job. And you're going to see some of that on Thursday. So thank you all very much. And we're going to sign this. And I think I'm going to have to give this pen -- the way I look at it, we should probably give it to Phil. What do you think?

PARTICIPANT: I agree.

THE PRESIDENT: Does everybody agree? I think Phil is --

REPRESENTATIVE ROE: I'll agree with that. (Laughter.)

THE PRESIDENT: Phil agrees. But congratulations, everybody. Really fantastic. Thank you very much.

(Bill is signed.) (Applause.)

Phil, maybe you could say a few words, if you'd like.

AMERICAN OVERSIGHT

REPRESENTATIVE ROE: Well, Mr. President, thank you very much. And this was a very, very important bill to get started with so we can get Choice 2.0 to get to the place exactly where the President said he wanted to be. And it's a privilege to work with all of these great people up here to help make the VA better.

I've spent the last week on the break going to Los Angeles and Phoenix to get a firsthand view of what's going on. And what we want to do is put the veteran in charge of these choices, not the bureaucracy. And I think Dr. Shulkin is just the person to see that happen. Mr. President, thank you so much.

THE PRESIDENT: Thank you very much. It's fantastic.

And David? Where's David?

DR. SHULKIN: Yeah, I'm right behind you, Mr. President.

THE PRESIDENT: Go ahead. I won't look back. You just talk. (Laughter.)

DR. SHULKIN: Well, first of all, I want to thank everybody here as well, and thank Congress for seeing this done, and Mr. President to be signing this.

This is a good day for veterans. This is a great day to celebrate not only what veterans have contributed to the country, but how we're making things better for them. And by working together, we're going to continue this progress. I think, as the President said, we're actually going to do this a week from Thursday, Mr. President --

THE PRESIDENT: Right.

DR. SHULKIN: -- and talk about the tremendous accomplishments, but most importantly, about the great things that are to come to fulfill the President's commitments that he made to veterans. And so thank you all for being here today.

AMERICAN OVERSIGHT

THE PRESIDENT: Thank you. Great job. So again, next week, on Thursday, at 2 o'clock -- it may change a little bit, but about that time we're going to have a conference to talk about the progress and the achievement.

I'd like to ask Rick Scott, the governor of Florida -- he's done a fantastic job as governor, by the way, and really understands his subject, and really understands a lot of subjects. Rick, do you want to say a few words?

GOVERNOR SCOTT: Sure. Well, I was really proud. My father was in the 82nd Airborne, he did all the combat jumps, and I grew up listening to all his stories about the war. I had the opportunity to serve in the Navy. Unfortunately, in 2014, I had to sue the VA because we had -- our state healthcare agency couldn't go inspect their hospitals when we heard all the stories about deaths, delays, and poor conditions.

And so Mr. President and I want to thank Congress for doing this to create certainty of care while we figure out how to fix the VA system. And David, I want to thank you for what you're doing. You've got actually the right background to do this. I know President Trump has been focused on our veterans and our military before he was President, and I know he's going to continue to do a great job. We have 1.5 million veterans. I want them all to move to Florida. (Laughter.) But thank you for doing this, Mr. President.

THE PRESIDENT: Thank you very much.

Most importantly, thank you, thank all of the great veterans. Would you like to say something to all of these people out there? You'll become a movie star tomorrow. (Laughter.)

PARTICIPANT: Well, our nation will be judged by how it treats its veterans, and I'm sure our country will allow generations -- right now, they're children, but they're going to be our future servicemen. And so we have to treat veterans well. It's about national security, it's about patriotism, and this is a great step forward to doing it.

THE PRESIDENT: Thank you very much. Nobody can say it better than that, so we're going to end. But I want to just thank you all. Thank you for being here. Thank you. (Applause.)

END 11:40 A.M. EDT

AMERICAN OVERSIGHT

Unsubscribe

The White House · 1600 Pennsylvania Avenue, NW · Washington DC 20500 · 202-456-1111

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Message

From: IP [(b) (6) frenchangel59.com]
Sent: 4/20/2017 2:53:24 PM
To: brucem(b) (6) @mac.com; mbs(b) (6) @gmail.com; Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
CC: lper(b) (6) @gmail.com
Subject: FW: Remarks by President Trump at Signing of S. 544, The Veterans Choice Program Extension and Improvement Act

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Sent: Thursday, April 20, 2017 10:38 AM
To: (b) (6) who.eop.gov; (b) (6) who.eop.gov; (b) (6) (b) ((b) (6) who.eop.gov
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Ike

https://m.youtube.com/watch?v=AufMXIGtr-Q

http://www.militarytimes.com/articles/trump-va-reform-veterans-affairs-choice-card

http://www.washingtontimes.com/news/2017/apr/19/donald-trump-signs-extension-veterans-choice-healt/

http://abcnews.go.com/Health/wireStory/trump-extends-private-sector-health-care-program-vets-46887778

AMERICAN OVERSIGHT

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We met earlier today in the Oval Office, and Secretary Shulkin updated me on the massive and chronic challenge he inherited at the VA, but also the great progress that he is making. He's got a group of people that are phenomenal at the VA. It's one of my most important things. I've been telling all of our friends at speeches and rallies for two years about the VA, how we're going to turn it around. And we're doing that.

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And, actually, next week, on Thursday at 2 o'clock, we're going to have a news conference with David and some others to tell you about all of the tremendous things that are happening at the VA and what we've done in terms of progress and achievement.

The veterans have poured out their sweat and blood and tears for this country for so long, and it's time that they're recognized, and it's time that we now take care of them, and take care of them properly.

That's why I'm pleased today to sign into law the Veterans Choice Program Improvement Act. So this is called the Choice Program Improvement Act. It speaks for itself. This bill will extend and improve the Veterans Choice Program so that more veterans can see the doctor of their choice -- you got it? The doctor of their choice -- and don't have to wait and travel long distances for VA care. Some people have to travel five hours, eight hours, and they'll have to do it on a weekly basis, and even worse than that. It's not going to happen anymore.

This new law is a good start, but there is still much work to do. We will fight each and every day to deliver the long-awaited reforms our veterans deserve, and to protect those who have so courageously protected each and every one of us.

So we've made a lot of strides for the veterans. These are, like, the most incredible people we have in our country as far as I'm concerned, and they have not been taken care of properly.

I want to thank David. You've done an incredible job. And you're going to see some of that on Thursday. So thank you all very much. And we're going to sign this. And I think I'm going to have to give this pen -- the way I look at it, we should probably give it to Phil. What do you think?

PARTICIPANT: I agree.

THE PRESIDENT: Does everybody agree? I think Phil is --

REPRESENTATIVE ROE: I'll agree with that. (Laughter.)

THE PRESIDENT: Phil agrees. But congratulations, everybody. Really fantastic. Thank you very much.

(Bill is signed.) (Applause.)

Phil, maybe you could say a few words, if you'd like.

REPRESENTATIVE ROE: Well, Mr. President, thank you very much. And this was a very, very important bill to get started with so we can get Choice 2.0 to get to the place exactly where the President said he wanted

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to be. And it's a privilege to work with all of these great people up here to help make the VA better.

I've spent the last week on the break going to Los Angeles and Phoenix to get a firsthand view of what's going on. And what we want to do is put the veteran in charge of these choices, not the bureaucracy. And I think Dr. Shulkin is just the person to see that happen. Mr. President, thank you so much.

THE PRESIDENT: Thank you very much. It's fantastic.

And David? Where's David?

DR. SHULKIN: Yeah, I'm right behind you, Mr. President.

THE PRESIDENT: Go ahead. I won't look back. You just talk. (Laughter.)

DR. SHULKIN: Well, first of all, I want to thank everybody here as well, and thank Congress for seeing this done, and Mr. President to be signing this.

This is a good day for veterans. This is a great day to celebrate not only what veterans have contributed to the country, but how we're making things better for them. And by working together, we're going to continue this progress. I think, as the President said, we're actually going to do this a week from Thursday, Mr. President --

THE PRESIDENT: Right.

DR. SHULKIN: -- and talk about the tremendous accomplishments, but most importantly, about the great things that are to come to fulfill the President's commitments that he made to veterans. And so thank you all for being here today.

THE PRESIDENT: Thank you. Great job. So again, next week, on Thursday, at 2 o'clock -- it may change a little bit, but about that time we're going to have a conference to talk about the progress and the achievement.

I'd like to ask Rick Scott, the governor of Florida -- he's done a fantastic job as governor, by the way, and really understands his subject, and really understands a lot of subjects. Rick, do you want to say a few words?

GOVERNOR SCOTT: Sure. Well, I was really proud. My father was in the 82nd Airborne, he did all the combat jumps, and I grew up listening to all his stories about the war. I had the opportunity to serve in the Navy. Unfortunately, in 2014, I had to sue the VA because we had -- our state healthcare agency couldn't go inspect their hospitals when we heard all the stories about deaths, delays, and poor conditions.

AMERICAN OVERSIGHT

And so Mr. President and I want to thank Congress for doing this to create certainty of care while we figure out how to fix the VA system. And David, I want to thank you for what you're doing. You've got actually the right background to do this. I know President Trump has been focused on our veterans and our military before he was President, and I know he's going to continue to do a great job. We have 1.5 million veterans. I want them all to move to Florida. (Laughter.) But thank you for doing this, Mr. President.

THE PRESIDENT: Thank you very much.

Most importantly, thank you, thank all of the great veterans. Would you like to say something to all of these people out there? You'll become a movie star tomorrow. (Laughter.)

PARTICIPANT: Well, our nation will be judged by how it treats its veterans, and I'm sure our country will allow generations -- right now, they're children, but they're going to be our future servicemen. And so we have to treat veterans well. It's about national security, it's about patriotism, and this is a great step forward to doing it.

THE PRESIDENT: Thank you very much. Nobody can say it better than that, so we're going to end. But I want to just thank you all. Thank you for being here. Thank you. (Applause.)

END 11:40 A.M. EDT

Unsubscribe

The White House · 1600 Pennsylvania Avenue, NW · Washington DC 20500 · 202-456-1111

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/28/2017 7:17:06 PM
To: David Shulkin [drshulkin@aol.com]; David Shulkin [david.shulkin@va.gov]
CC: (b) (6) va.gov
Subject: Fwd: updated datapalooza slides
Attachments: Datapalooza draft 3.pptx; ATT00001.htm

I used these slides today- please update your access website slides

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6) va.gov>
To: "VHA USH Meeting Requests" <VHAUSHMeetingRequests@va.gov>
Cc: "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>, "Poonam Alaigh ((b) (6) hotmail.com)" <(b) (6) hotmail.com>
Subject: updated datapalooza slides

AMERICAN OVERSIGHT



Datapalooza

Presented by Dr. Poonam Alaigh, Acting Under Secretary for Health
Datapalooza
4/28/2017

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Veterans Health Administration

0

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Top 5 Priorities for VA



Greater Choice

- VA Telehealth
- MyHealtheVet
- VA Mobile Apps



Modernize Systems

- eHMP
- JLV
- EHR



Efficiency

- MVP
- Big Data
- Precision Medicine



Improve Timeliness

- Accesstocare@va.gov



Suicide Prevention

- ReachVet
- Telemental Health Hubs

1

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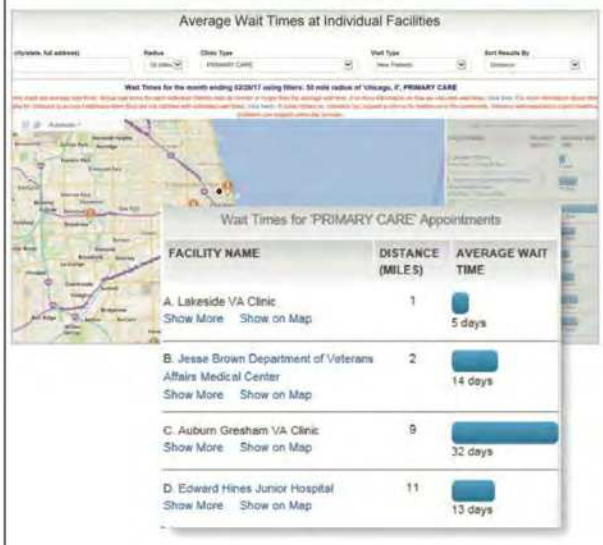
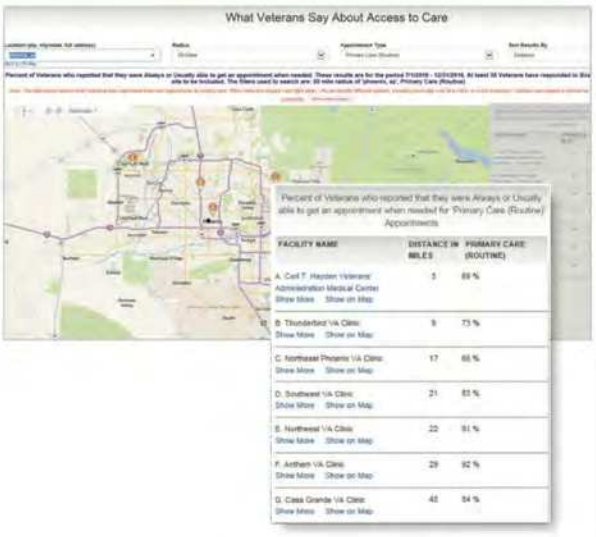
2

AMERICAN OVERSIGHT

AVERAGE LOCAL CLINIC WAIT TIMES

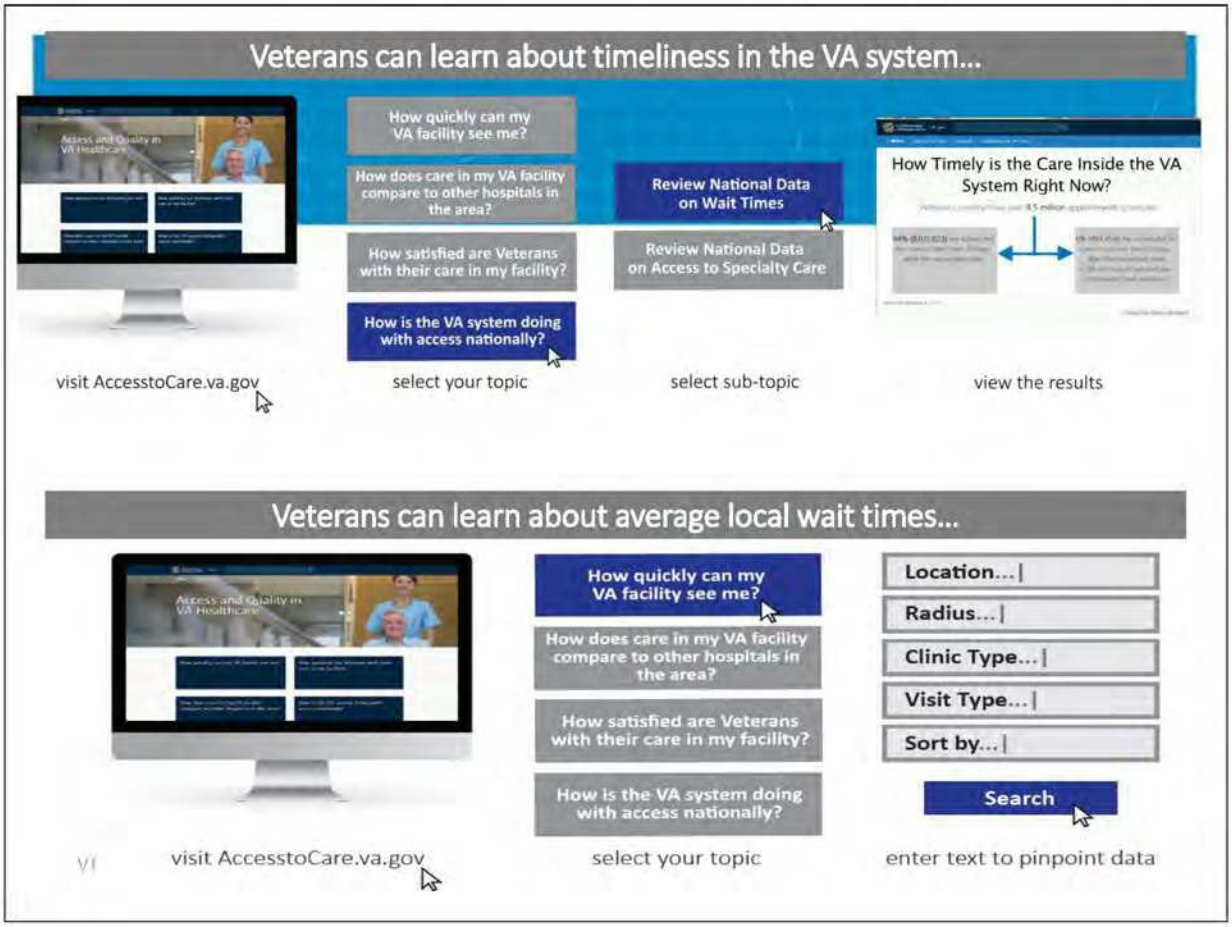
VETERAN SATISFACTION WITH ACCESS





VETERANS HEALTH ADMINISTRATION

AMERICAN OVERSIGHT



4

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Feedback?

- This is a work in progress and we are working hard to make it better for Veterans
- If you have expertise in communicating complex information to broad stakeholders or user testing please reach out
- Contact VHA10E2Action@va.gov with insights, feedback, or general interest



VETERANS HEALTH ADMINISTRATION

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Message

From: Marisol Garcia [(b) (6) frenchangel59.com]
Sent: 4/15/2017 10:43:56 AM
To: L Perl [(b) (6) gmail.com]; (b) (6) hotmail.com; David shulkin [Drshulkin@aol.com]; Bruce Moskowitz [(b) (6) mac.com]; mbs(b) (6) @gmail.com; (b) (6) frenchangel59.com; (b) (6) va.gov
Subject: FRIENDLY REMINDER - VA Conference Call TODAY - Saturday, April 15th @10:00AM

Saturday, April 15th

10:00 AM – 10:45 AM EST

Dial-in Information:

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Participants:

Laurie Perlmutter, Poonam Alaigh, Secretary David Shulkin, Dr. Bruce Moskowitz, Marc Sherman and Ike

Thank you,

Marisol Garcia

212-576-(b) (6) (Office)

(646) 201-(b) (6) (Cell)

(b) (6) frenchangel59.com

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) gmail.com]
Sent: 4/14/2017 9:59:18 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fya article from today

http://www.lehighvalleylive.com/allentown/index.ssf/2017/04/veterans_affairs_secretary_vis.html

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/13/2017 4:34:18 PM
To: (b) (6) [(b) (6) va.gov]
Subject: Fwd: [EXTERNAL] (b) (6)

Fyi

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) RDML USN WHMO/WHMU" <(b) (6) whmo.mil>
Date: April 13, 2017 at 12:20:42 PM EDT
To: David shulkin <Drshulkin@aol.com>
Subject: RE: [EXTERNAL] (b) (6)

David,
Meant to send this to you yesterday. Suspect you may have intended it for the other

BTW, everyone loves what you are doing over there and you are making great headlines! Hope to see you soon.

R/
(b) (6)

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Wednesday, April 12, 2017 10:43 AM
To: Bruce Moskowitz <(b) (6) mac.com>
Cc: (b) (6) RDML USN WHMO/WHMU <(b) (6) whmo.mil>
Subject: Re: [EXTERNAL] (b) (6)

My office is working on it

I have a keynote to 1000 people till 2 but then could get to a meeting

We have some rearranging to do but will work on it

Sent from my iPhone

On Apr 12, 2017, at 8:58 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> Mr. (b) (6) asked if you can attend the Bethesda meeting.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> Begin forwarded message:
>
> **From:** "(b) (6) <(b) (6) va.gov>
> **Date:** April 12, 2017 at 8:53:59 AM EDT

AMERICAN OVERSIGHT

To: Bruce Moskowitz <(b) (6) mac.com>
Subject: RE: [EXTERNAL] (b) (6)

Yes. Good call with (b) (6) Have call with (b) (6) today.

Meeting with (b) (6) et al: Friday, 28 April. Details TBD. Likely at around 2 or 3pm.

(b) (6)
805 551 (b) (6)

-----Original Message-----
From: Bruce Moskowitz [mailto:(b) (6) mac.com]
Sent: Wednesday, April 12, 2017 8:40 AM
To: (b) (6)
Subject: [EXTERNAL] (b) (6)

Spoke to him today. When is the meeting at Bethesda?

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: [redacted] RDML USN WHMO/WHMU [[redacted]whmo.mil]
Sent: 4/13/2017 4:20:42 PM
To: David shulkin [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] [redacted]

David,
Meant to send this to you yesterday. Suspect you may have intended it for the other [redacted]

BTW, everyone loves what you are doing over there and you are making great headlines! Hope to see you soon.

R/
[redacted]

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Wednesday, April 12, 2017 10:43 AM
To: Bruce Moskowitz <[redacted]mac.com>
Cc: [redacted] RDML USN WHMO/WHMU <[redacted]whmo.mil>
Subject: Re: [EXTERNAL] [redacted]

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>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> Begin forwarded message:
>
> **From:** "[redacted] <[redacted]va.gov>
> **Date:** April 12, 2017 at 8:53:59 AM EDT
> **To:** Bruce Moskowitz <[redacted]mac.com>
> **Subject: RE: [EXTERNAL]** [redacted]
>
> Yes. Good call with [redacted] Have call with [redacted] today.
>
> Meeting with [redacted] et al: Friday, 28 April. Details TBD. Likely at around 2 or 3pm.
>
> [redacted]
> 805 551 [redacted]
>
> -----Original Message-----

AMERICAN OVERSIGHT

From: Bruce Moskowitz [mailto:(b) (6) mac.com]
Sent: Wednesday, April 12, 2017 8:40 AM
To: (b) (6)
Subject: [EXTERNAL] (b) (6)

Spoke to him today. When is the meeting at Bethesda?

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/12/2017 2:42:36 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: (b) (6) L. RDML USN WHMO/WHMU Jackson [(b) (6) whmo.mil]
Subject: Re: [EXTERNAL] (b) (6)

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I have a keynote to 1000 people till 2 but then could get to a meeting

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Sent from my iPhone

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> Sent from my iPad
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> Begin forwarded message:
>
> **From:** "(b) (6) <(b) (6) va.gov>
> **Date:** April 12, 2017 at 8:53:59 AM EDT
> **To:** Bruce Moskowitz <(b) (6) mac.com>
> **Subject: RE: [EXTERNAL]** (b) (6)
>
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>
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>
> (b) (6)
> 805 551 (b) (6)
>
> -----Original Message-----
> From: Bruce Moskowitz [mailto:(b) (6) mac.com]
> Sent: Wednesday, April 12, 2017 8:40 AM
> To: (b) (6)
> Subject: [EXTERNAL] (b) (6)
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AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/12/2017 12:58:20 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: [EXTERNAL] (b) (6)

Mr. (b) (6) asked if you can attend the Bethesda meeting.

Sent from my iPad
Bruce Moskowitz M.D.

Begin forwarded message:

From: "(b) (6) <(b) (6) va.gov>
Date: April 12, 2017 at 8:53:59 AM EDT
To: Bruce Moskowitz <(b) (6) mac.com>
Subject: RE: [EXTERNAL] (b) (6)

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Meeting with (b) (6) et al: Friday, 28 April. Details TBD. Likely at around 2 or 3pm.

(b) (6)
805 551 (b) (6)

-----Original Message-----
From: Bruce Moskowitz [mailto:(b) (6) mac.com]
Sent: Wednesday, April 12, 2017 8:40 AM
To: (b) (6)
Subject: [EXTERNAL] (b) (6)

Spoke to him today. When is the meeting at Bethesda?

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/15/2017 2:04:40 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Musical chairs

I know, but still like to ask you

Sent from my iPad

> On Apr 14, 2017, at 6:54 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> You have my support to do what you feel is best
>
> Sent from my iPhone
>
>> On Apr 14, 2017, at 5:04 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>
>> Yes, Gerry wants to try her. Don't really trust her but spoke to her yesterday and told her that I wanted no gossip, needed to work on trust issues and no direct contact to the 10th floor now the Jen will be there. The deputy pdush role gives me some degrees of separation while being able to leverage her talent, and nobody reports to her. Agree about mike, although the is about to retire and this may incentivize him to stay longer by challenging him in a new way
>>
>> Sent from my iPhone
>>
>>> On Apr 13, 2017, at 10:53 PM, David Shulkin <drshulkin@aol.com> wrote:
>>>
>>> I would definitely move Dort- she adds no value- does Gerry want her or should she go to the field?
>>>
>>> I think Ash has value- it's up to u if u trust her
>>>
>>> I don't know who would take over for Mike- Pharmacy is not broken so please make sure you don't break it by removing him
>>>
>>> Sent from my iPad
>>>
>>>> On Apr 13, 2017, at 10:43 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>>>
>>>> With all this happening around us-thinking of making additional moves- what do you think?
>>>>
>>>> 1) Ash- deputy PDUSH- she works on all the quick hit priorities like the IG reports denoting system wise issues like the inventory management
>>>>
>>>> 2) Mike Valentino- becomes deputy to Lu Beck
>>>>
>>>> 3) Deb Dort- moves to Gerry Cox area
>>>>
>>>> Sent from my iPhone
>>>
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/14/2017 10:54:06 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Musical chairs

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Sent from my iPhone

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>>> 2) Mike Valentino- becomes deputy to Lu Beck
>>>
>>> 3) Deb Dort- moves to Gerry Cox area
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>>> Sent from my iPhone
>>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/14/2017 9:04:55 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Musical chairs

Yes, Gerry wants to try her. Don't really trust her but spoke to her yesterday and told her that I wanted no gossip, needed to work on trust issues and no direct contact to the 10th floor now the Jen will be there. The deputy pdush role gives me some degrees of separation while being able to leverage her talent, and nobody reports to her. Agree about mike, although the is about to retire and this may incentivize him to stay longer by challenging him in a new way

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>
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>>
>> 3) Deb Dort- moves to Gerry Cox area
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/14/2017 2:53:35 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Musical chairs

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I don't know who would take over for Mike- Pharmacy is not broken so please make sure you don't break it by removing him

Sent from my iPad

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>
> 2) Mike Valentino- becomes deputy to Lu Beck
>
> 3) Deb Dort- moves to Gerry Cox area
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/14/2017 2:43:37 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Musical chairs

With all this happening around us-thinking of making additional moves- what do you think?

1) Ash- deputy PDUSH- she works on all the quick hit priorities like the IG reports denoting system wise issues like the inventory management

2) Mike Valentino- becomes deputy to Lu Beck

3) Deb Dort- moves to Gerry Cox area

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/15/2017 4:52:49 PM
To: (b) (6) gmail.com
Subject: Re: Smag

yes

-----Original Message-----
From: (b) (6) <(b) (6) gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Apr 15, 2017 6:27 am
Subject: Smag

Hi, We talked about smag last week, and you said you were just going to talk about the priorities. I wanted to double check to see if that was still the case.

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Message

From: [redacted] [redacted]gmail.com]
Sent: 4/15/2017 10:27:51 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Smag

Hi, We talked about smag last week, and you said you were just going to talk about the priorities. I wanted to double check to see if that was still the case.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 6/3/2017 10:24:16 PM
To: David shulkin [Drshulkin@aol.com]
CC: Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Re:

Agree and I concur with his guidance - surprises it's not already in place to that effect

Sent from my iPhone

On Jun 3, 2017, at 4:14 PM, David shulkin <Drshulkin@aol.com> wrote:

> https://correa.house.gov/media/press-releases/rep-correa-sends-secretary-shulkin-letter-veteran-use-medical-marijuana
>
> Can we discuss this at report
>
> Im ok if you need sme but i think its unnecessary- i think we just need a policy clarification about his issue
>
> Thanks
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 6/3/2017 8:14:43 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: Vivieca Wright Simpson [vivieca.Wright@va.gov]

https://correa.house.gov/media/press-releases/rep-correa-sends-secretary-shulkin-letter-veteran-use-medical-marijuana

Can we discuss this at report

Im ok if you need sme but i think its unnecessary- i think we just need a policy clarification about his issue

Thanks

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/25/2017 12:31:00 PM
To: IP [(b) (6)frenchangel59.com]
Subject: Re: RE:

(b) (6)

Sent from my iPhone

> On Apr 25, 2017, at 7:48 AM, IP <(b) (6)frenchangel59.com> wrote:
>
> Please email me his/her name. Thank you
>
> -----Original Message-----
> From: David shulkin [mailto:Drshulkin@aol.com]
> Sent: Tuesday, April 25, 2017 6:48 AM
> To: Ike Perlmutter
> Subject:
>
> Ike- the DoD top person for health will come to dinner Wednesday
>
> Im still working on isakkson
>
> David
>
> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/25/2017 11:48:31 AM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE:

Please email me his/her name. Thank you

-----Original Message-----
From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Tuesday, April 25, 2017 6:48 AM
To: Ike Perlmutter
Subject:

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David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/25/2017 10:48:09 AM
To: Ike Perlmutter [(b) (6)frenchangel59.com]

Ike- the DoD top person for health will come to dinner Wednesday

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David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/16/2017 1:24:28 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: How are things

I am on the Accela 2255 train- let me know if there is anything I can do.

From: David Shulkin <drshulkin@aol.com>
Sent: Sunday, April 16, 2017 9:19 AM
To: (b) (6) hotmail.com
Subject: Re: How are things

a lot going on

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Apr 15, 2017 7:42 pm
Subject: How are things

On the home front

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 1:19:13 PM
To: (b) (6) hotmail.com
Subject: Re: How are things

a lot going on

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From: Poonam Alaigh <(b) (6) hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Apr 15, 2017 7:42 pm
Subject: How are things

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/15/2017 11:42:21 PM
To: David Shulkin [drshulkin@aol.com]
Subject: How are things

On the home front

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/18/2017 3:16:08 AM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: PELOSI -- Remarks at Veterans Health Care Action Campaign Forum

You deserve a huge congratulations for that. Everything else she got wrong, unfortunately.

On Mon, Apr 17, 2017 at 10:05 PM, David shulkin <Drshulkin@aol.com> wrote:
Of all people look what Nancy Pelosi said in yellow below

Subject: FW: PELOSI -- Remarks at Veterans Health Care Action Campaign Forum

Sir,

Leader Pelosi had a Veterans event in San Francisco at the end of last week with Michael Blecker, Swords to Plowshares.

Her staff forwarded her remarks, which included positive things about you that are highlighted.

V/R, (b) (6)

From: Democratic Leader
Sent: Thursday, April 13, 2017 7:12 PM
Subject: PELOSI -- Remarks at Veterans Health Care Action Campaign Forum

NANCY PELOSI
DEMOCRATIC LEADER

News
FROM DEMOCRATIC LEADER NANCY PELOSI
DEMOCRATICLEADER.GOV

Contact: Jorge Aguilar,

202-226-7616

April 13, 2017

AMERICAN OVERSIGHT

Pelosi Remarks at Veterans Health Care Action Campaign Forum

San Francisco – Democratic Leader Nancy Pelosi joined Michael Blecker, Executive Director of Swords to Plowshares, veterans and leaders of veterans advocacy groups at the Veterans Health Care Action Campaign Forum. Below is a transcript of the Leader's remarks:

"Thank you, everyone. Thank you Michael [Blecker] for your great leadership and your kind words of welcome. Thank you Paul Cox for your leadership as well, to be here with you and Michael Blecker, of course with Suzanne Gordon, we'll all be looking forward to her speech, and Edgar Escobar thank you for your leadership. I also want to acknowledge my daughter, Christine Pelosi who is here, she is a member of the Democratic National Committee, and she was the leader in insisting they have Veterans desk at the Democratic National Committee.

"Michael will tell you he wrote the dissenting view on Commission on Care. I was so very grateful. I'm so very, very proud of him, I've seen his work for decades – as Paul has mentioned he's been working with Swords to Plowshares for a long time, so I've been aware of his leadership for a long time on behalf of our vets. So, I was very honored recently to appoint him to the Commission on Care, but even earlier than that to our regular meeting with Veteran Service Organizations, going back to when I first became Leader almost a dozen years ago, and then Speaker, and then Leader again.

"But Michael when he would come, I would say, 'I'd like to introduce you to a saint.' He would blush as he's blushing now, but not for long. He would soon speak up on behalf of veterans there. We had our most recent meeting just about a week or so ago before we broke for Easter and Passover, and I want to say it was as usual very informative, a very strong meeting but this time very much focused, and that is a decision by the vets.

"At this meeting, we focused on women veterans and the rising list of concerns that we have for women veterans. That's a very large and growing, number as well. But we always take our agenda from what the veterans bring, going back to our first meeting. We talked about the Veteran's Disability Tax in Congress, issues the relate to Survivor Benefits. You name it, just a full array of issues, but saying to you prioritize, we'll act upon it.

"When we had the Majority [in Congress], we were able to allocate the resources necessary to implement some of the policy that we were able to achieve earlier. I was very proud of all of the – I'll put up a self-serving sign – when I was introduced the Commander said what I had done as Speaker was recognized more than any other Speaker in terms of meeting the needs of veterans since the GI Bill. So we're very, very excited about that. It's a recognition of your work.

AMERICAN OVERSIGHT

"But I am here today to listen, that's definitely the most valuable thing. I learn more when I listen than when I speak. And I come here to listen to your concerns, but I want to put it in this context.

"A couple days ago we had a social media call where we meet with all of the groups – VoteVets, Daily Kos, Move On, Planned Parenthood, all these groups – about how we can protect the Affordable Care Act. Well in the meantime Syria intervened, so our veterans were an even stronger voice, they're always strong, but we had more questions for them on the call. And at the end of the call they said, 'We're talking about vets, and we're talking about the VA, that's very important to us, but our veterans need to go beyond the VA.'

"It's about housing and how HUD is funded, it's about mental health, it's about the Affordable Care Act and other issues. It's about Medicaid, it's about Opioids which is about the Medicaid solution that we have in our legislation and so they said, 'there are so many other things that effect our well-being, as important as the VA is one of the most important things that affects us is we like to have peace, so we can get well.'

[Applause]

"Because as we know, and you've heard it over and over, you've said it yourself – when you're on the battle field you leave no soldier behind, and when they come home we leave no veteran behind. That is our mantra, and you have to help us make that happen.

"Because as Michael said, when he was named to this Commission the issue is they're not listening to vets, they're just talking to each other. And this threat loomed large during the Presidential campaign, privatizing the VA is a real threat. We will not let them make money off of delivering health care to our veterans and that's a promise.

[Applause]

"We've got to move our own health care system to a more nonprofit place, rather than moving our Veterans Health Administration to a 'Let's make more off our Vets' place.

"So in our meeting, a group that represents nobody but has money from somebody, Conservative Veterans of America, I don't think anyone here is part of it, but if you are I want you to hear what I have to say – the

AMERICAN OVERSIGHT

VA and Veterans Services Organizations are unified. Now, having said that, if we're going to address concerns that we have, making delivery of service better – do we recognize how that fits very much in our health care system and how we need other things – need other things.

"I had one of those penchants this morning, we planted a garden to start the construction of the barrier and net at the Golden Gate Bridge. We spent a lot of time with families who have lost their loved one – taking their own lives. We know that that is an increasing problem across the board in our country, including among our veterans. So, our mental health issues are very, very important, and in fact, we're very dismayed that our colleagues across the aisle did not make addressing mental health issues – they took off of the list of things that must be done.

"So, let's look up here: Veterans' Health Care Action Campaign. Veterans – it's about our veterans' health care. They're taking action and having a campaign. Understand this very clearly: nothing is more eloquent to a Member of Congress than the voice of his or her own constituents. You're my bosses, or if you're not in my district, you're somebody else's bosses. So, let your voice be known to them, as well. Your experience is the wisdom that we need to make the decisions when we have choices to make. Of all of the things President Trump has done, one thing I am happy about is his choice for Secretary of Veterans' Affairs – the secretary there. So far, so good. Wouldn't you say? So far, so good – because we thought for sure he was going to put a privatizer at the head of the VA, and that would've been very problematic. We'll see how we go from there.

"A couple of other thoughts – just to say, today – this spring is the 100th anniversary since our entry into World War I, 75 years since the Bataan Death March, 14 years since the invasion of Iraq. So sad. So sad. And, so many veterans are coming home. So, we are getting hundreds of thousands of servicemembers each year – becoming veterans, challenging our system. Over 70 percent of our nation's 21 million are over the age of 45, including the majority of veterans in San Francisco. As I mentioned, many more women, and we need to address [each] of those concerns – and that's why we have regular veterans service organizations' meetings, and that's why I am here to hear what you have to say, on the ongoing but as a group here today.

"Again, we are very concerned about this issue of privatization. Privatization can virtually end the guarantee – end the guarantee of free health care for those who have served. Privatization would see the VA's doors closed for most of its 366,000 employees, a third of whom are veterans themselves – 100,000 of the workers in the VA are vets. While ensuring the VA can better coordinate care in a community where there are gaps, we have to be smart, we have to be cautious. Nearly one-third percent of care is already provided outside of the VA – you know that. Increasing the amount of care outside of the VA could have negative impacts on comprehensive and specialty care. There are just some things the VA knows better – combat related injuries and the rest. There are just some things they can diagnose more readily, care for with experience in having cared for others. At the VA, veterans are treated as a whole person. That is the only service-connected, comprehensive care culture that provides unparalleled, personal medical expertise.

AMERICAN OVERSIGHT

"We must lift, not load. VA privatization is not the answer. I look forward to our forum and debunking the myth of what veterans' choice really means – what that really means. We have to hold our bedrock promise. Again, just as the military leaves no one behind on the battlefield, we must leave no veteran behind when they come. That is our promise – not only that, it is our values system, it is an ethical commitment that we have to you. You make us the home of the brave and the land of the free. And while we're doing that, we have to also consider what they're doing in the budget. The budget should be a statement of our national values. What is important to us as a nation should be reflected in our budget. When veterans come from [overseas], we need the biomedical research, we need these other things that they are cutting because this is something that we all benefit from. So, as a statement of our values, our veterans are not at that place – the place that we want them to be.

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"So, thank you for all that you have done for our country, for your leadership, for your service and for your concern, not only about you but for so many other veterans as they come back home. Thank you all very much for [giving me] the time to share some thoughts with you. I look forward to hearing what you all have to say. Thank you all very much."

###

Press Release Link:

AMERICAN OVERSIGHT

http://www.democraticleader.gov/newsroom/41317-3/

DemocraticLeader.gov – Twitter – YouTube – Flickr – Facebook – Instagram – Medium – The Gavel

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/18/2017 2:05:37 AM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]; Marc Sherman [(b) (6) gmail.com]
Subject: Fwd: PELOSI -- Remarks at Veterans Health Care Action Campaign Forum

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NANCY PELOSI
DEMOCRATIC LEADER

News
FROM DEMOCRATIC LEADER NANCY PELOSI
DEMOCRATICLEADER.GOV

Contact: Jorge Aguilar,

202-226-7616

April 13, 2017

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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"So, thank you for all that you have done for our country, for your leadership, for your service and for your concern, not only about you but for so many other veterans as they come back home. Thank you all very much for [giving me] the time to share some thoughts with you. I look forward to hearing what you all have to say. Thank you all very much."

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Press Release Link:

AMERICAN OVERSIGHT

http://www.democraticleader.gov/newsroom/41317-3/

DemocraticLeader.gov – Twitter – YouTube – Flickr – Facebook – Instagram – Medium – The Gavel

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/14/2017 10:53:06 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Announcement

I think its nice of you

Sent from my iPhone

On Apr 14, 2017, at 5:34 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> I sent this to Jen last night- you may not agree with what I said, but David, I cant purposely hurt anyone ever.
>
> David, my true friend, you are a blessing in my life!!
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
> **Date:** April 14, 2017 at 5:25:01 AM EDT
> **To:** 'Poonam Alaigh' <(b) (6) hotmail.com>
> **Subject: FW: Announcement**
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** Alaigh, Poonam, M.D.
> **Sent:** Thursday, April 13, 2017 09:45 PM Eastern Standard Time
> **To:** Lee, Jennifer S. (VACO)
> **Cc:** Hyduke, Barbara
> **Subject:** Announcement
>
> Jennifer, Barbara and the team will work on the announcement tomorrow. Just got off the phone with Lu Beck and she has agreed to step into the role as an acting deputy effective Monday.
>
> Jennifer, I want to thank you so much your commitment and dedication in VHA, and feel the loss already. But as you know, the boss gets what he wants. And he wants you now- more importantly, he needs you! I know you will be successful in this new role- we will talk more tomorrow.
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>
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AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6) hotmail.com]
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/13/2017 2:11:56 AM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: draft note

Your confidence in him was important to me

Sent from my iPhone

On Apr 12, 2017, at 9:51 PM, Darin Selnick <(b) (6) @gmail.com> wrote:

> I am forwarding this from Larry to you as he wanted to make sure it reached you. He is deeply honored that you gave him this opportunity and the confidence you have in him.
>
> Darin
>
> ---------- Forwarded message ----------
> From: **Larry Connell** <(b) (6) gmail.com>
> Date: Wed, Apr 12, 2017 at 5:32 PM
> Subject: draft note
> To: (b) (6) k@gmail.com
>
> Dr. Shulkin,
>
> Just a quick note to say thanks for this one in a lifetime opportunity. I greatly appreciate your confidence in me and my pledge to you is to ensure we regain the trust of our Veterans at the D.C. VA Medical Center. I will make you proud.
>
> Thanks,
>
> Larry
>
> Larry Connell
>
> (b) (6) gmail.com
>
> (210) 764-9530

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/13/2017 1:51:23 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Fwd: draft note

I am forwarding this from Larry to you as he wanted to make sure it reached you. He is deeply honored that you gave him this opportunity and the confidence you have in him.

Darin

---------- Forwarded message ----------
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Date: Wed, Apr 12, 2017 at 5:32 PM
Subject: draft note
To: (b) (6) @gmail.com

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Larry

Larry Connell

(b) (6) @gmail.com

(210) 764-9530

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/14/2017 11:54:17 PM
To: Marisol Garcia [(b) (6) frenchangel59.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; (b) (6) va.gov
Subject: Re: Conference call for tomorrow Saturday, April 15, 2017

Yes 10
Am works

Sent from my iPhone

On Apr 14, 2017, at 4:43 PM, Marisol Garcia <(b) (6) frenchangel59.com> wrote:

> Thank you – Laurie prefers 10am ---
>
> David, please let me know.
>
> ---
>
> **From:** Poonam Alaigh [mailto:(b) (6) hotmail.com]
> **Sent:** Friday, April 14, 2017 4:38 PM
> **To:** Marisol Garcia
> **Cc:** David shulkin; (b) (6) va.gov
> **Subject:** Re: Conference call for tomorrow Saturday, April 15, 2017
>
> I can make myself available at a time that works for everyone- preferably 9am or later. Thanks
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> On Apr 14, 2017, at 4:33 PM, Marisol Garcia <(b) (6) frenchangel59.com> wrote:
>
> > Poonam and David,
> >
> > Laurie and Ike would like to have a call tomorrow morning.
> >
> > Please let me know as soon as possible what time works best:
> >
> > ***10:00 AM or 11:00 AM for 45 minutes***
> >
> > ***Participants:***
> > ***Laura Perlmutter, Poonam Alaigh, Secretary Shulkin, Dr. Bruce Moskowitz, Marc Sherman and Ike***
> >
> > Thank you,
> > Marisol

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From: Marisol Garcia [(b) (6) frenchangel59.com]
Sent: 4/14/2017 8:43:19 PM
To: 'Poonam Alaigh' [(b) (6) hotmail.com]
CC: 'David shulkin' [Drshulkin@aol.com]; (b) (6) va.gov
Subject: RE: Conference call for tomorrow Saturday, April 15, 2017

Thank you – Laurie prefers 10am —

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From: Poonam Alaigh [mailto(b) (6) hotmail.com]
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>
> Thank you,
> Marisol

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Message

From: Yehia, Baligh R. [Baligh.Yehia@va.gov]
Sent: 4/17/2017 2:58:08 AM
To: 'David Shulkin' [drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: draft for the choice demonstration pilots

Sounds good. Will do.

Sent with Good (www.good.com)

-----Original Message-----
From: David Shulkin [drshulkin@aol.com]
Sent: Sunday, April 16, 2017 11:03 AM Eastern Standard Time
To: Yehia, Baligh R.
Subject: [EXTERNAL] Fwd: draft for the choice demonstration pilots

A demo as Darin defines might be good but I would like to build into the main legislation as much as we can to allow us to bill for other health insurance and to operate with the same rules as private sector hospitals and systems. Worse case is that it gets taken out.

-----Original Message-----
From: Darin Selnick <(b) (6) [redacted]@gmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sat, Apr 15, 2017 11:09 am
Subject: Fwd: draft for the choice demonstration pilots

FYI

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Darin

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Date: Thu, Apr 13, 2017 at 10:31 PM
Subject: draft for the choice demonstration pilots
To: "Yehia, Baligh R." <Baligh.Yehia@va.gov>
Cc: "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>, "(b) (6) [redacted]k@gmail.com" <(b) (6) [redacted]@gmail.com>

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AMERICAN OVERSIGHT

Darin Selnick
Senior Advisor to the Secretary
Cell 202-390-5845

AMERICAN OVERSIGHT

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From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 3:03:35 PM
To: (b) (6) gmail.com
Subject: Fwd: draft for the choice demonstration pilots
Attachments: Community of Care and VAMC Health Care Delivery Modernization.docx

please print this attachemnt

-----Original Message-----
From: David Shulkin <drshulkin@aol.com>
To: baligh.yehia <baligh.yehia@va.gov>
Sent: Sun, Apr 16, 2017 11:02 am
Subject: Fwd: draft for the choice demonstration pilots

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Community of Care and VAMC Health Care Delivery Modernization Demonstration Pilots

Overview of Concept

The purpose of the demonstration pilots is to see if VA can operate its healthcare system more effectively both in access and in cost, using the best practices of the TRICARE and the private sector, to improve the delivery of healthcare to veterans. For the demonstration pilots, VHA would separate its payer and provider functions into two different operating units and move them from the existing HMO staff model to a HMO mixed model.

A HMO mixed model is when the community care provider network is a combination of delivery systems. The VA demonstration pilots HMO mixed model will offer a wide variety of choices and broad geographic coverage to its veteran's members. Patients will have the choice of VHA and Community Care clinics, labs, pharmacies, and hospitals as their providers of care. In the VA demonstration pilots, the HMO mixed model would be a combination of a the VAMCs and CBOCs operating as a group model accountable care organization, such as the Cleveland Clinic or Kaiser Permanente, and the Community Care operating as a contracted provider network, such as United Healthcare or TRICARE.

Key Components

Payer: The VA demonstration payer pilots would be operated as the Veterans Health Plan (VHP). It would have the ability to operate using the best practices from private sector health plans and from government payers.

In addition to using the new VA community care RFP, it would have legislative relief from any government contracting and acquisition regulations that would impede its ability to operate and compete with private sector HMO contracted provider networks. Key operating function would include:

- Cost mitigation using secondary payer: Like TRICARE, VHP would be secondary payer for all veterans who have other health insurance, including for all service connected and non-service connected services that the OHI would normally pay for as part of its benefits package. The current estimate is that 80% of veterans enrolled in VA healthcare have OHI. This would mean that VHP would pay after all OHI, including all other government and private insurance programs. VHP would be primary payer for any benefits that the veteran would be entitled to as part of the VA healthcare benefit, but is not part of their OHI benefit.
- Primary coordinator of benefits: To ensure veterans are not balance billed, VHP would act as the primary coordinator of benefits to ensure veterans are not charged inappropriately by their OHI and would receive an EOB which would list the charges and

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what is owed by the veteran. VHP would ensure the veterans OHI would process the providers claim first and be responsible to settle all disputes.

- Balance billing: By law, VHP like TRICARE would prohibit the practice of balance billing. Balance billing requirements would apply to both network and non-network providers who treat VHP beneficiaries and noncompliance would impact their VHP and/or Medicare, Medicaid or FEHB status.
- Governance – Board of Directors: An overall board of directors would provide governance and operational oversite for the demonstration pilots. The board would consist of the SECVA, USH, PDUSH, DUSHs, leading healthcare experts, and veteran representation.

Provider

The VA demonstration provider pilots would be operated as the Veterans Clinic. As the Veterans Clinic, it would be set up and have the ability to operate on a level playing field with private sector provider healthcare organizations. It would be able to use the same best practices that private sector provider accountable care organizations such as the Cleveland Clinic, Mayo Clinic and Kaiser Permanente use

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- Control of facilities and footprint: The board of directors would have complete authority and control over its facilities and footprint. Other governmental agencies and Congress would not be able to block lawful decisions.
- Leadership: Each demonstration pilot would have a traditional private sector provider structure headed by a CEO that would report to the board of directors. They would have a 5 year contract but could be terminated by the board due to poor performance.
- Revenue: The dollars would follow the patient. Each demonstration pilot would have provider contracts with all payers, including both government (Medicare, Medicaid, FEHB), private sector managed care and commercial. The Veterans Clinics would be reimbursed for all services provided the same as private provider groups. If there is excess capacity each pilot would have the option to open up to non-eligible veterans and family members who would be pay the full premium through their OHI.

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- Benefit Package: All eligible veterans would have the same existing benefit package they currently do. VHP would have to pay the gap between what the veteran OHI authorized benefit package and VHP. Non-eligible veterans and families would only be offered services that are 100% paid for by their OHI.
- Efficiency: All Veterans Clinic would have to operate based on the revenue provided by the payers. It would be expected that they would have to improve their operations to be more efficient to match their revenue.
- Accountable Care Organization functions: The Veteran Clinics would operate following the primary characteristics of an ACO to include strong primary, specialty and hospital care with effective cost control and quality of care:
    - Capacity to manage both the cost and quality of health care services under a range of payment systems.
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    - Commitment to achieve quality and cost efficiencies, a physician management structure and a culture that supports and rewards continuous quality improvement.
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Demonstration pilot sites

- Arizona: Senate Sponsor - Senator McCain
- Washington: House Sponsor – Rep McMorris Rodgers

Time Frame

- Demonstration pilots would be required to be set up and fully operational within one year after the legislation had been passed by congress and signed by the President.
- Demonstration pilots after the one year set up period would run for five years with an automatic five year extension unless congress voted to end the extensions.

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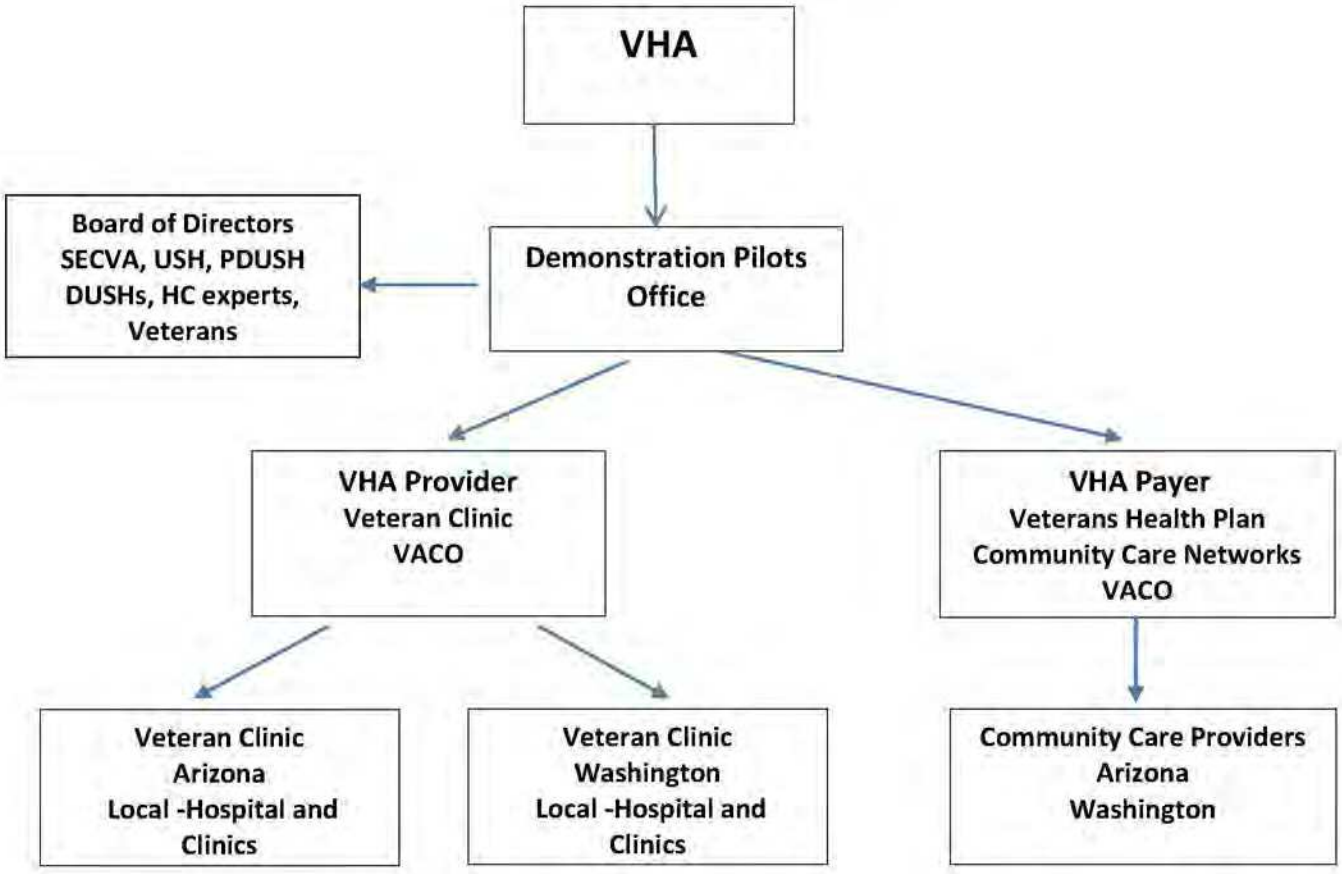
Organizational Structure

VHA – Mixed Model Demonstration Pilots
(Payer and Provider Organization)



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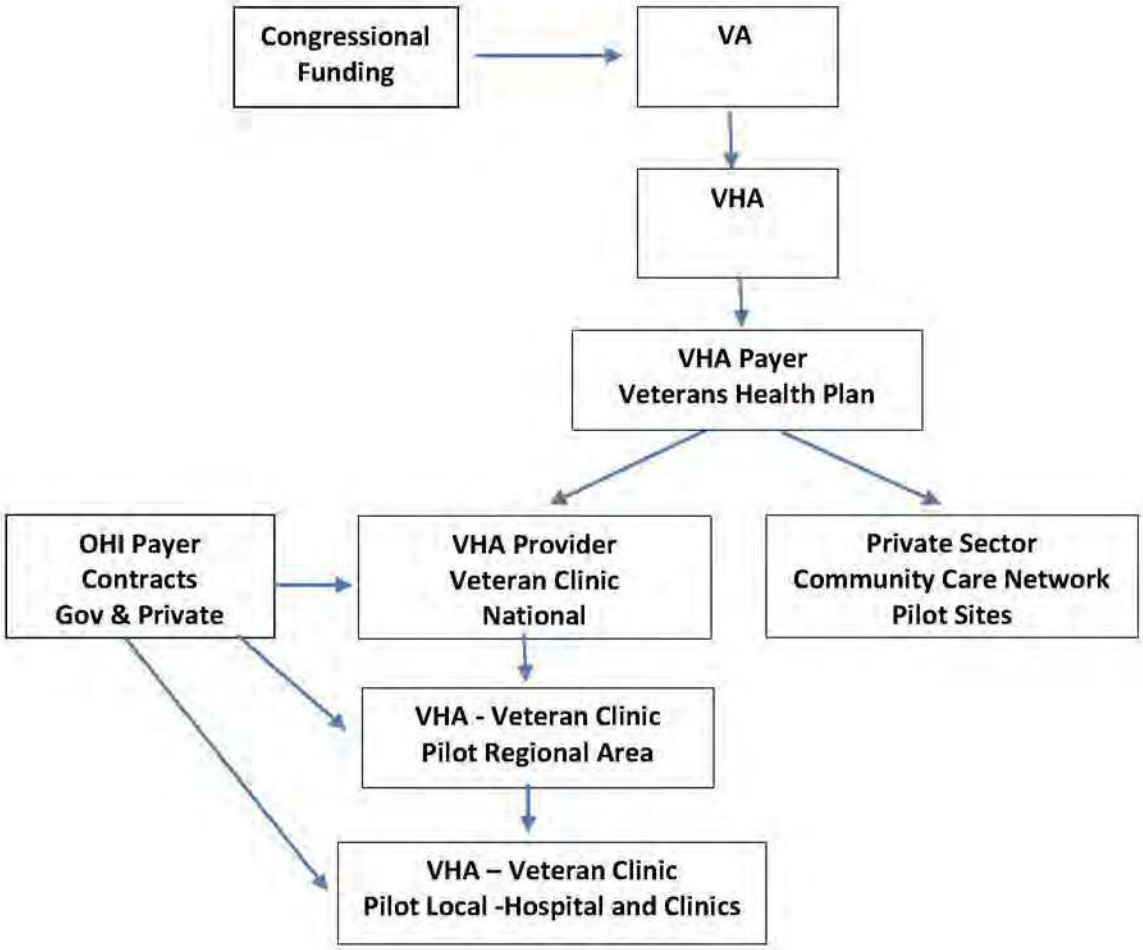
Revenue Flow

VHA Revenue
(Payer and Provider)



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Revenue from Payers
Veterans OHI %



LEGEND
Payer
Veteran OHI %
Revenue

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 3:02:51 PM
To: baligh.yehia@va.gov
Subject: Fwd: draft for the choice demonstration pilots
Attachments: Community of Care and VAMC Health Care Delivery Modernization.docx

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AMERICAN OVERSIGHT

Community of Care and VAMC Health Care Delivery Modernization Demonstration Pilots

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AMERICAN OVERSIGHT

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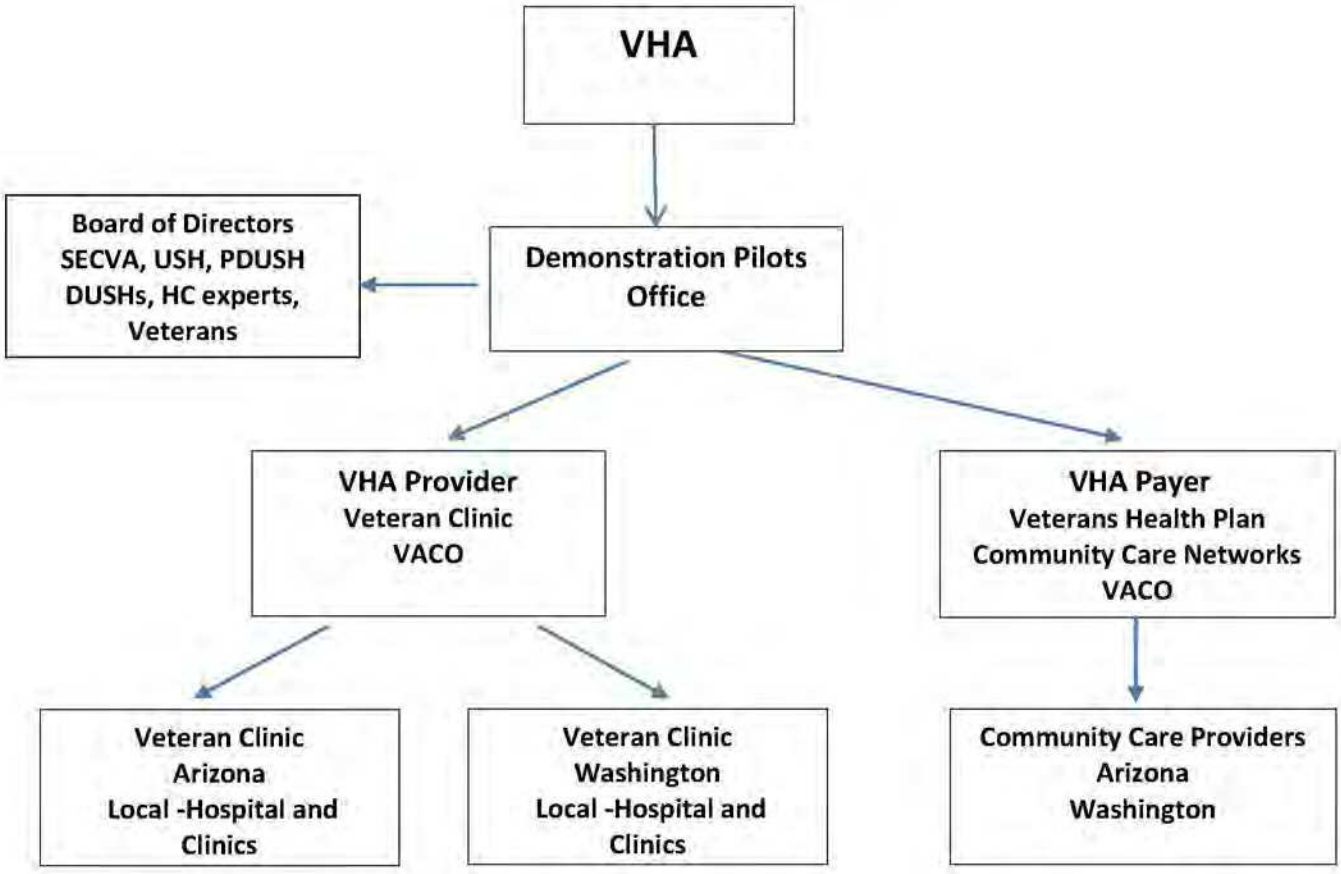

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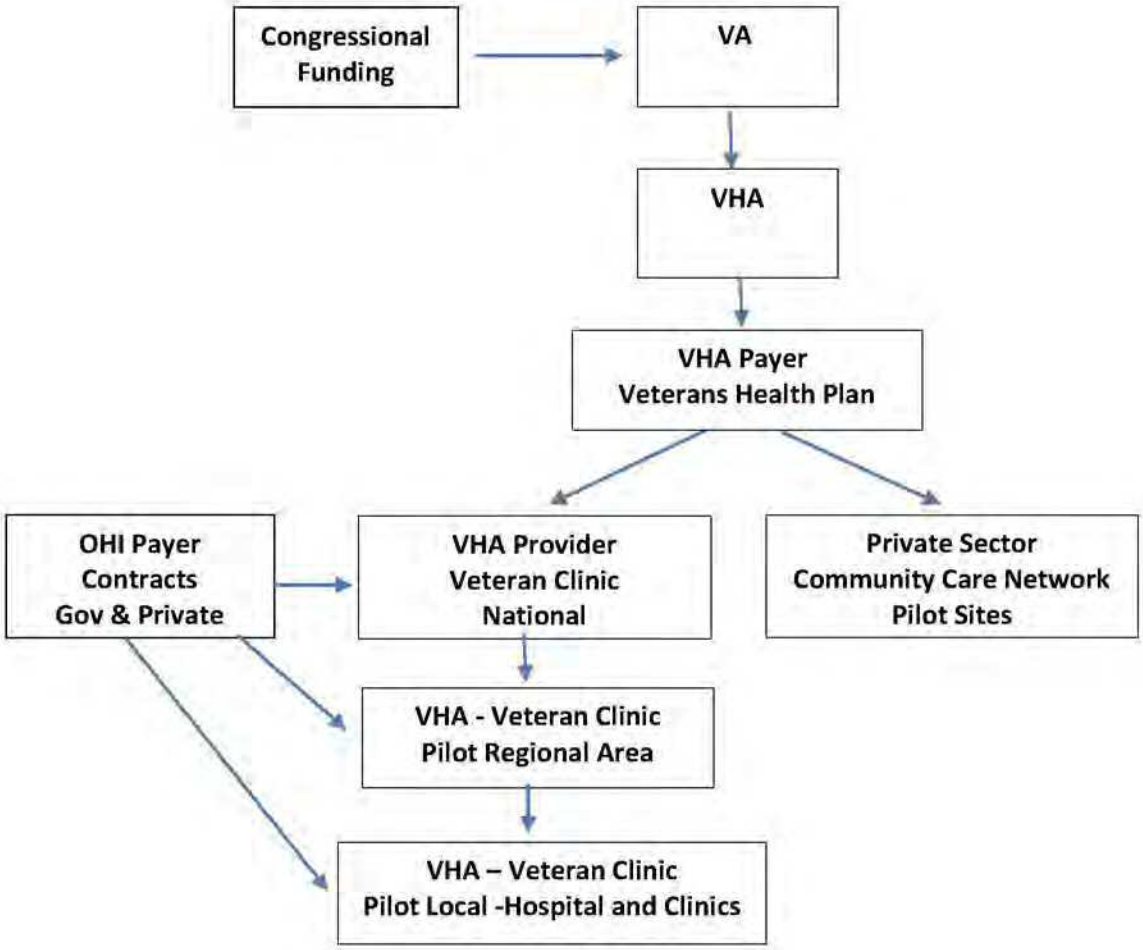
Revenue Flow

VHA Revenue
(Payer and Provider)



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Revenue from Payers
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LEGEND
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- Governance – Board of Directors: An overall board of directors would provide governance and operational oversite for the demonstration pilots. The board would consist of the SECVA, USH, PDUSH, DUSHs, leading healthcare experts, and veteran representation. The board of director would have oversight from Congress.
- Control of facilities and footprint: The board of directors would have complete authority and control over its facilities and footprint. Other governmental agencies and Congress would not be able to block lawful decisions.
- Leadership: Each demonstration pilot would have a traditional private sector provider structure headed by a CEO that would report to the board of directors. They would have a 5 year contract but could be terminated by the board due to poor performance.
- Revenue: The dollars would follow the patient. Each demonstration pilot would have provider contracts with all payers, including both government (Medicare, Medicaid, FEHB), private sector managed care and commercial. The Veterans Clinics would be reimbursed for all services provided the same as private provider groups. If there is excess capacity each pilot would have the option to open up to non-eligible veterans and family members who would be pay the full premium through their OHI.

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- Benefit Package: All eligible veterans would have the same existing benefit package they currently do. VHP would have to pay the gap between what the veteran OHI authorized benefit package and VHP. Non-eligible veterans and families would only be offered services that are 100% paid for by their OHI.
- Efficiency: All Veterans Clinic would have to operate based on the revenue provided by the payers. It would be expected that they would have to improve their operations to be more efficient to match their revenue.
- Accountable Care Organization functions: The Veteran Clinics would operate following the primary characteristics of an ACO to include strong primary, specialty and hospital care with effective cost control and quality of care:
    - Capacity to manage both the cost and quality of health care services under a range of payment systems.
    - Have comprehensive, valid and reliable performance measurements, make internal system improvements in care quality and externally report on its performance on cost and quality of care
    - Commitment to achieve quality and cost efficiencies, a physician management structure and a culture that supports and rewards continuous quality improvement.
    - Use of health information technology to manage patients across the continuum of care and across different institutional settings.

Demonstration pilot sites

- Arizona: Senate Sponsor - Senator McCain
- Washington: House Sponsor – Rep McMorris Rodgers

Time Frame

- Demonstration pilots would be required to be set up and fully operational within one year after the legislation had been passed by congress and signed by the President.
- Demonstration pilots after the one year set up period would run for five years with an automatic five year extension unless congress voted to end the extensions.

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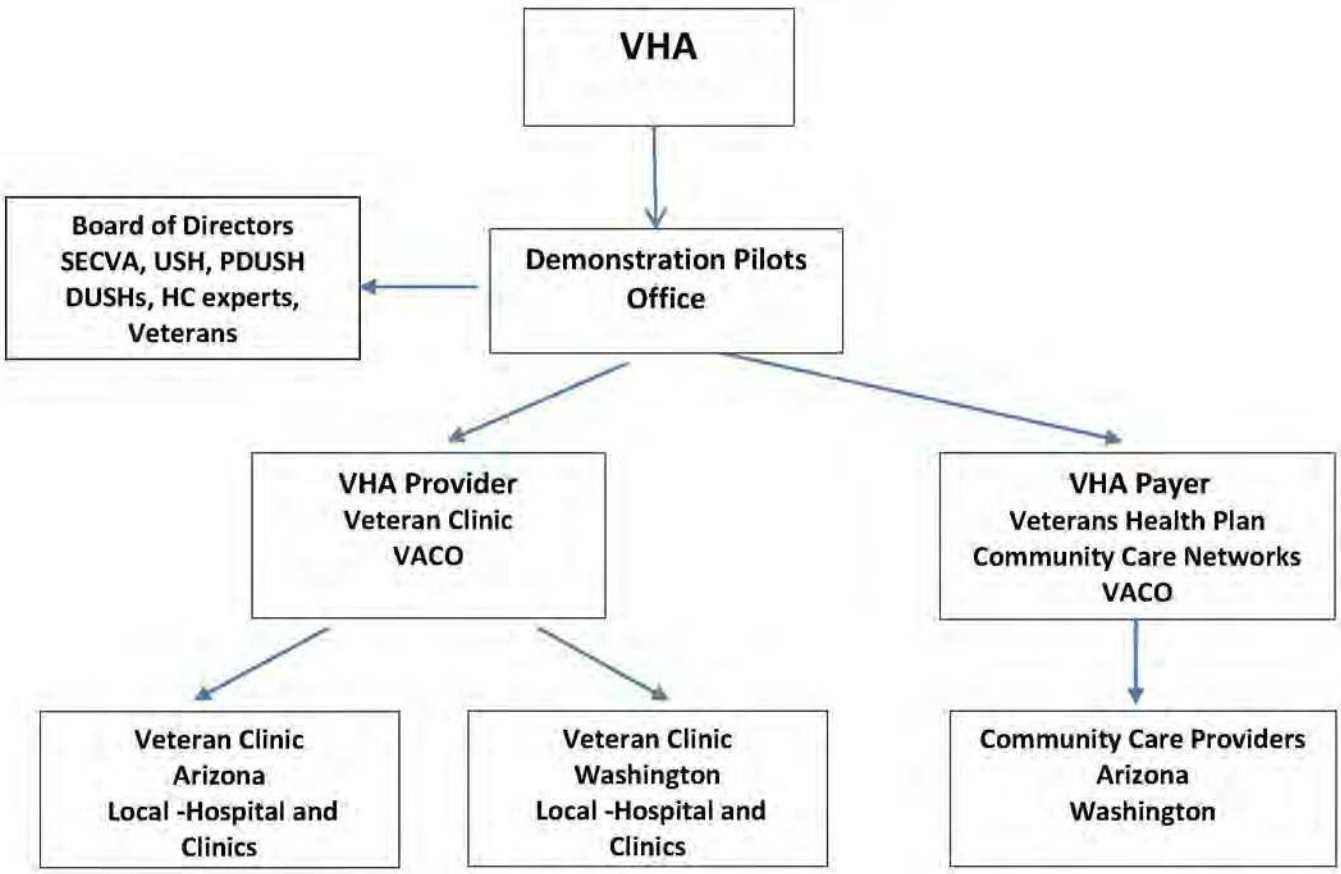
Organizational Structure

VHA – Mixed Model Demonstration Pilots
(Payer and Provider Organization)



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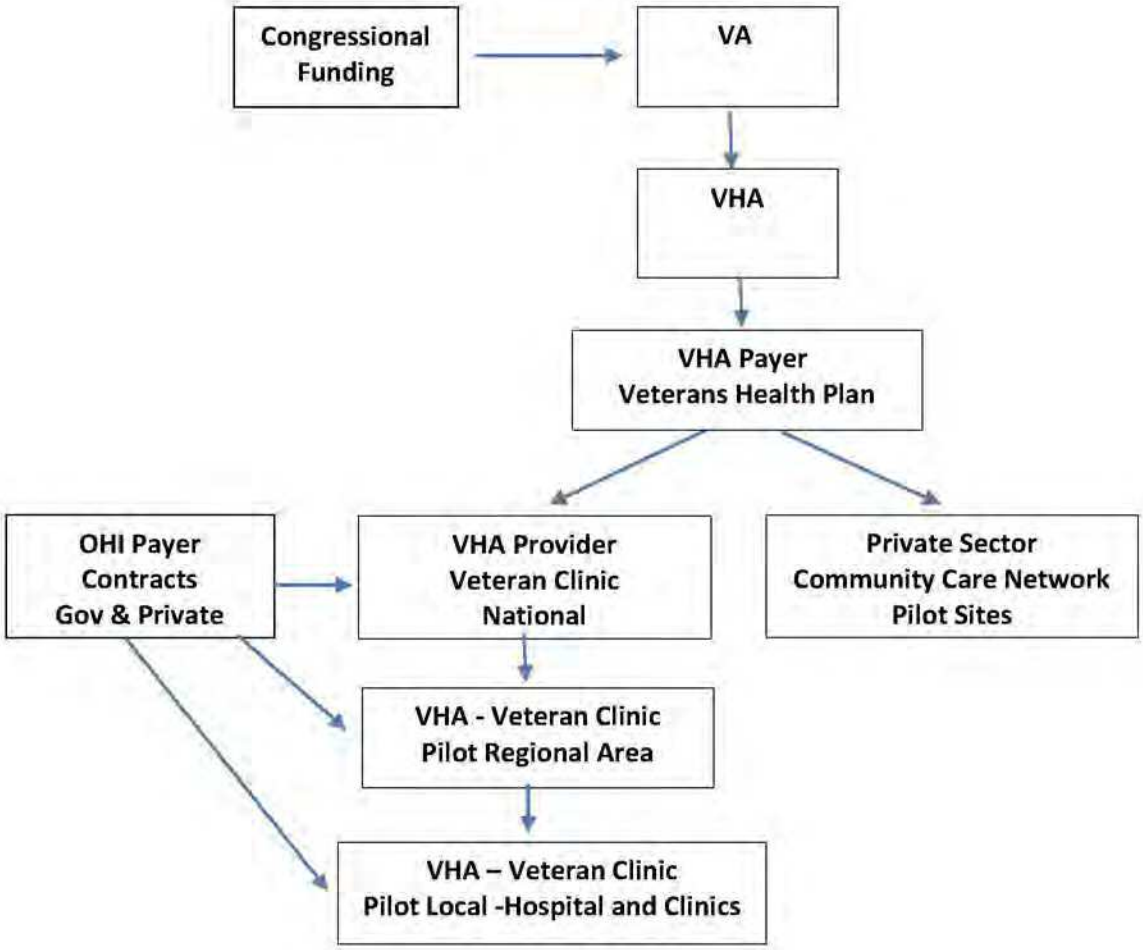
Revenue Flow

VHA Revenue
(Payer and Provider)



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Revenue from Payers
Veterans OHI %



LEGEND
Payer
Veteran OHI %
Revenue

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/16/2017 1:21:17 PM
To: (b) (6) gmail.com
Subject: early draft for april 25th
Attachments: april25thtoppriorities.pptx

There is still more to work on but so far this is what I have if we want to begin to work from this

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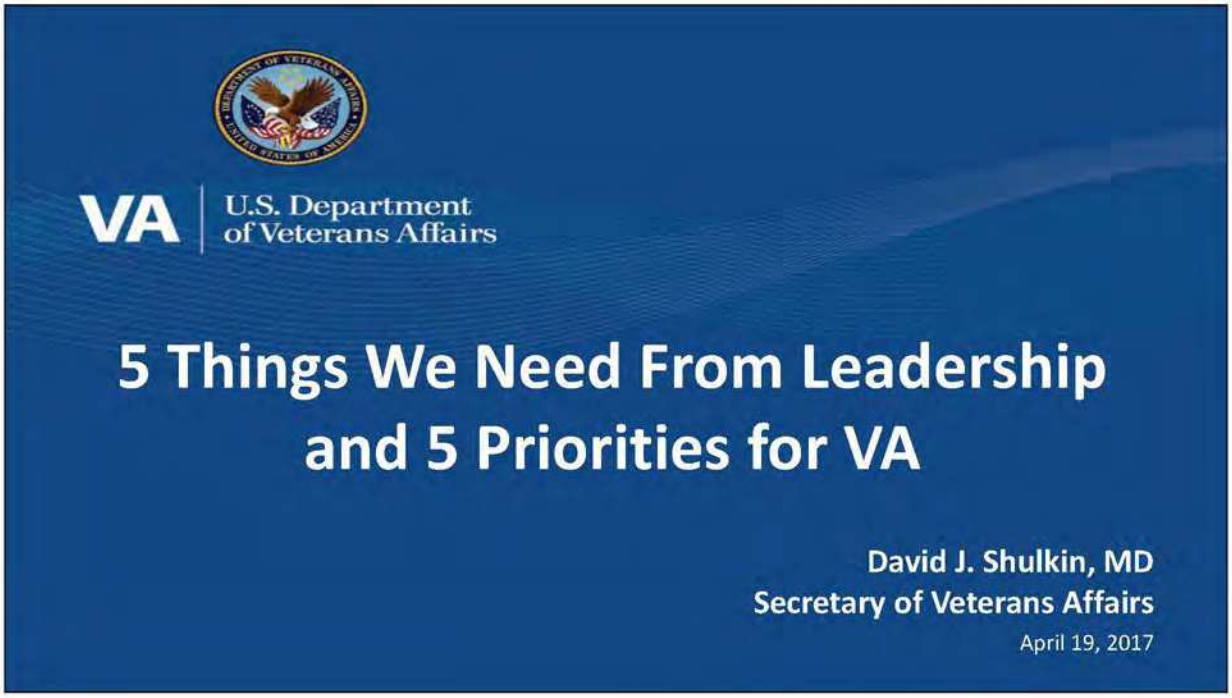

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1. Don't Plan for Incremental Change



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Events at the DC VA Acting Decisively



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2- Run Towards the Gun Fire





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Making Tough Decisions



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United's Response



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3. Demonstrate Your Commitment to the Mission



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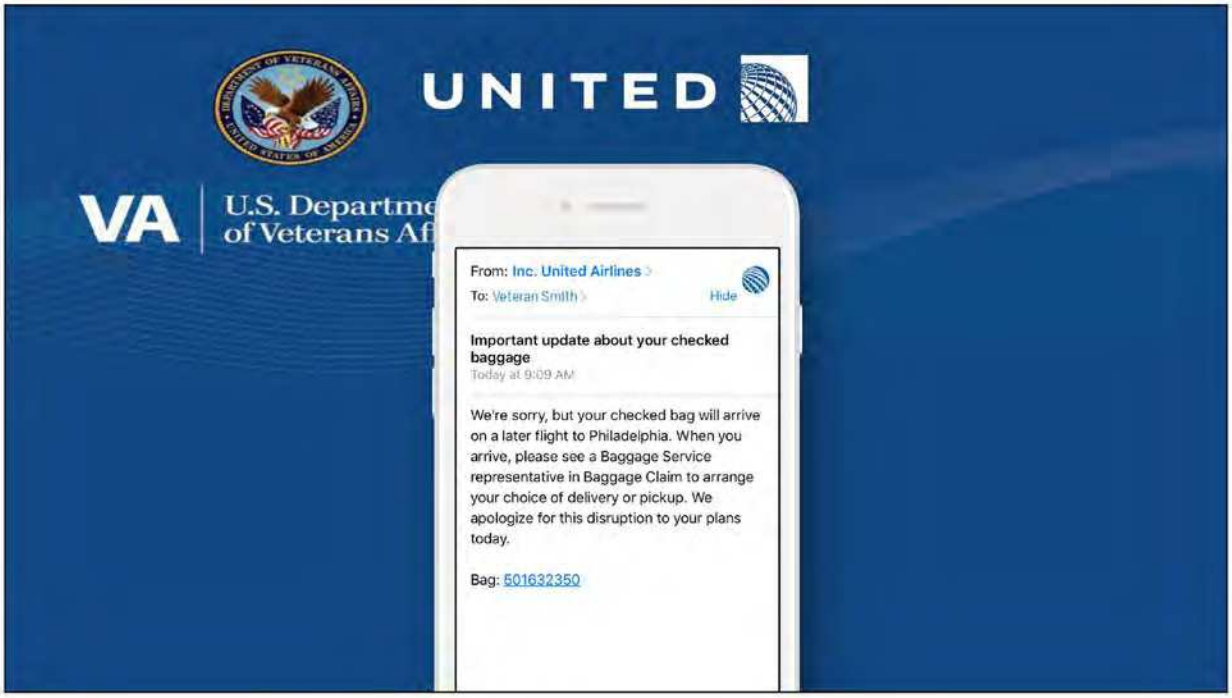

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4. Focus On Your People





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Rid Organizations of Bad Actors (Stop Detailing)

"Dealing with employee issues

can be difficult,

but *not dealing with them*

can be worse."

- Paul Foster, CEO and Founder, The Business Therapist®

Business

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5- Ask the Right Questions

Two Things Every Leader Needs to Know:

- **Am I pushing too hard or not hard enough?**
- **What don't I know that is likely to damage the organization?**

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The Secretary's 5 Priorities

1. Greater Choice for Veterans
2. Modernize our Systems
3. Focus Resources More Efficiently
4. Improve Timeliness of Services
5. Suicide Prevention



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1. Greater Choice for Veterans

- Redesign the 40/30 Rule to use clinical criteria for choice

  veteran choice
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information

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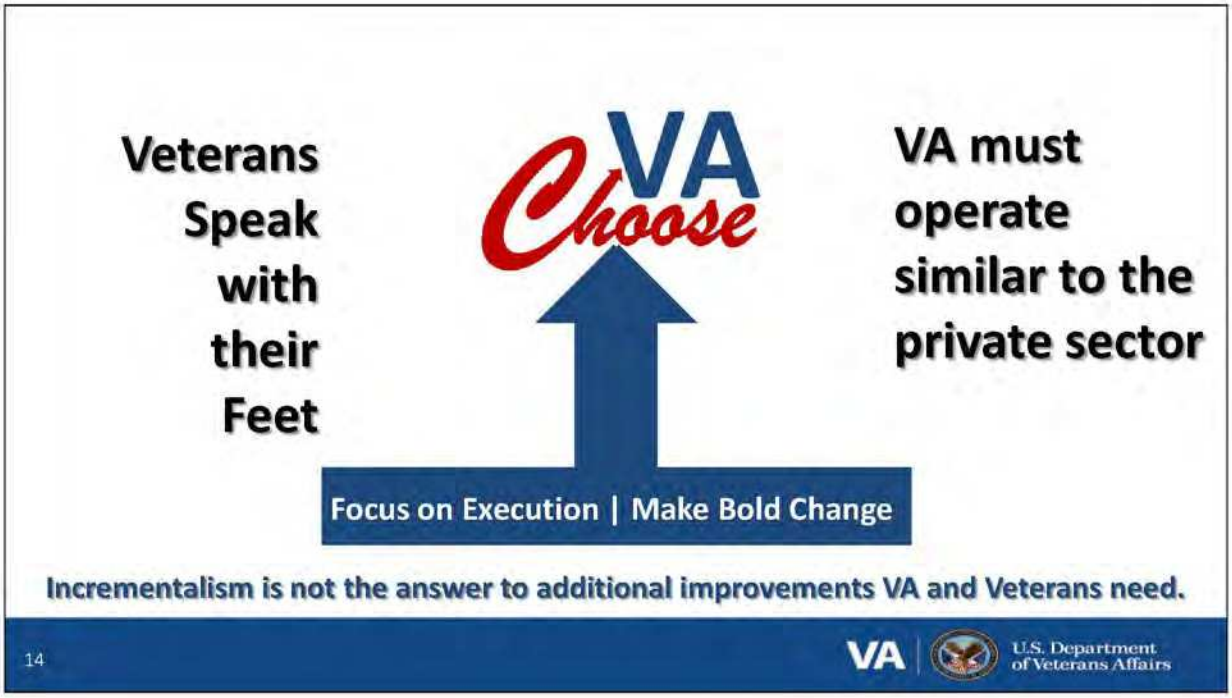

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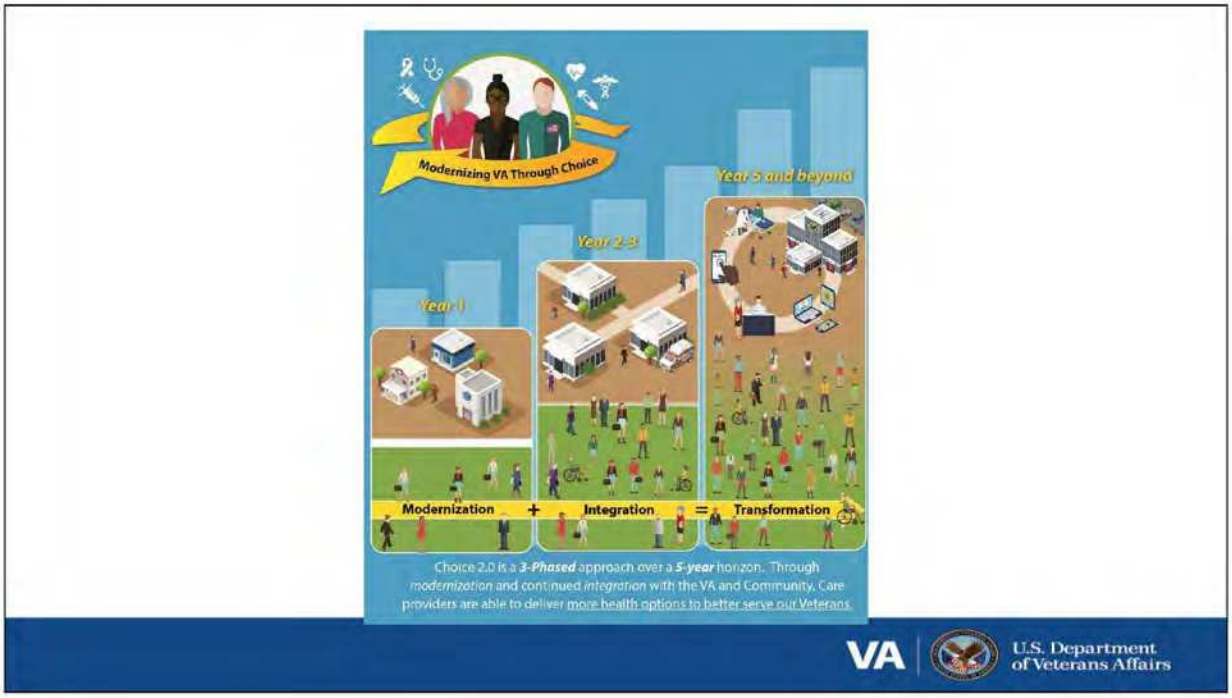

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2- Modernize Our Systems

- Infrastructure improvements and streamlining services
- EMR interoperability and IT modernization

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Infrastructure Improvements



Officers' Quarters
Fort Thomas, KY
Circa 1895



Gas Station
Minneapolis, MN
1932



Palo Alto VAMC
2017

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3. Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

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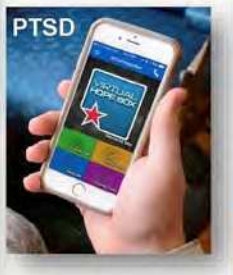
World Class Foundational Services











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Accountability Legislation



Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Direct Hire for Medical Center Directors and Network Directors	Ability to fully utilize our relocation, recruitment, and retention awards	Authority to reccoop relocation expenses authorized through fraud of malfeasance.	Increased **protections for whistleblowers** .

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4. Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

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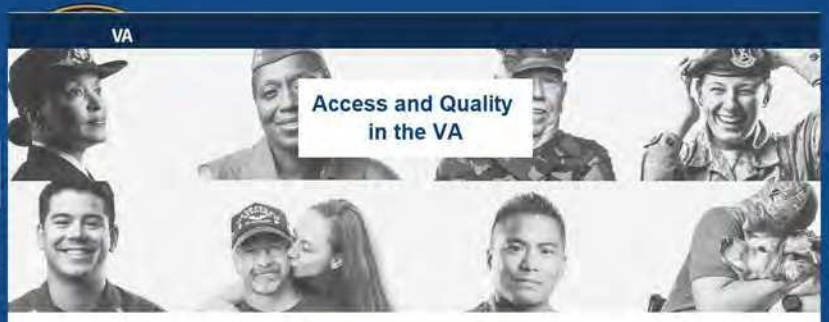
VA



How quickly does my VA see patients?

How satisfied are veterans like me with the timeliness of their care?

How well does my VA's care compare to other hospitals?

VA Pre-Decisional

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5- Suicide Prevention

- Getting to ZERO

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Suicide Prevention



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Suicide Prevention Coordinator Video Clip Here

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/14/2017 1:22:37 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: EHRM team.

Ed murray

Ill be glad to meet

Sent from my iPhone

On Apr 13, 2017, at 9:05 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> David, please see below- they need me to be the project sponsor in order to move forward in the direction below. I am getting a little concerned especially if we don't have a clear path- I think the team needs to meet with you and we should meet with the WH again soon to ensure we have all synced up. Also, they need a finance person on the team now- should I get Mark Yow involved or do you want someone from Ed Murrays area?
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "Alaigh, Poonam, M.D." <Poonam.Alaigh@va.gov>
> **Date:** April 13, 2017 at 8:57:58 PM EDT
> **To:** 'Poonam Alaigh' <(b) (6) hotmail.com>
> **Subject: FW: EHRM team.**
>
> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** (b) (6) J., Jr.
> **Sent:** Thursday, April 13, 2017 08:54 PM Eastern Standard Time
> **To:** Alaigh, Poonam, M.D.
> **Subject:** EHRM team.
>
> All,
> (b) (6) and I met with Dr. Alaigh this evening and I was given clear marching efforts to quickly and quietly usher our EHR Modernization effort with the DoD forward. (b) (6) and I sat down with (b) (6) on the phone to outline our key deliverables and dates, building from the schedule (b) (6) established. This email outlines our roles and responsibilities in the near term.
>
> EHRM Project Sponsor – Dr. Alaigh
> Team Lead – (b) (6)
> Clinical – (b) (6)

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OI&T – TBA (Dr. Alaigh requested from OI&T 4-13)
Legal – (b) (6) & (b) (6)
Contracts – (b) (6) (b) (6) David, (b) (6) and (b) (6)
Engineering – Digital Service
Financial & Appropriation – TBD (request from Dr. Alaigh 4-13)
Communications – via existing Mitre contract and VA Front office

I believe the following deliverables and dates are achievable, let's discuss on our daily call:

Deliverables:	Draft Due	Final Due
D&F – (b) (6)	Apr 18	Apr 21
PWS – OI&T & (b) (6) (DS)	Apr 20	Apr 26
IGCE – (b) (6)	Apr 20	Apr 26
RTM – (b) (6)	Apr 20	Apr 26
Station Code (aka MTF Codes – OIT lead & (b) (6)	Apr 20	Apr 26
Action Memo – (b) (6)	Apr 18	Apr 21
Financial Budget & Appropriations Language Changes	Apr 20	Apr 26
Acquisition Strategy – (b) (6) (if required)		

Tomorrow morning I have a meeting with DoD's Program Executive Officer Stacy Cummings. I have asked (b) (6) and (b) (6) to dial into that call.

I will send out a standing daily Team Call for our synchronization for 1PM EDT.

Upcoming Key Events:

D&F Signed	Apr 21
Team Lock Down	Apr 24 & 25 – TAC
Vendor Meeting & PWS Review	Apr 26
Site Visit – VAMC NY	Apr 27
Site Visit – VAMC Philly	Apr 28
Congressional Notification	Apr 24
White House Public Announcement	May 15

Please let me know if I missed anything or we need to discuss further.

Finally, I came to the VA just over a year ago to work on modernizing our EHR. This vision is quickly becoming a reality. It is both an honor and privilege to be working with such an esteemed TEAM on this incredibly important project for the VA and our Veterans.

Warm regards,
(b) (6)
Program Executive for EHR Modernization
(b) (6) - 703-587-(b) (6)

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/14/2017 1:05:28 AM
To: Drshulkin@aol.com
Subject: Fwd: EHRM team.

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RTM – [redacted] Apr 20 Apr 26
Station Code (aka MTF Codes – OIT lead & [redacted] Apr 20 Apr 26
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Warm regards,
[redacted]
Program Executive for EHR Modernization
[redacted] - 703-587-[redacted]

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Message

From: [redacted] [redacted]gmail.com]
Sent: 4/13/2017 7:01:06 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: Re: draft for studer group
Attachments: 2017 04 19-3 HURON CEO FORUM.pptx; 2017 04 19 Huron (Studer) CEO Forum Audience Analysis.docx

Here is a copy of the slides to review
---------- Forwarded message ----------
From: "Brian Mitchell" <[redacted]gmail.com>
Date: Apr 13, 2017 2:52 PM
Subject: Re: draft for studer group
To: "[redacted]" <[redacted]gmail.com>, "[redacted]" <[redacted]gmail.com>
Cc:

[redacted]

Here are the Huron slides, 51 in all, plus an audience analysis with most of what he'll need to know (bios, guest list).

I'll be out on leave for Easter tomorrow and Monday, in church and unavailable for work most of the time. Al will be in tomorrow, and Ed and [redacted] will be back Monday.

I don't expect there will be much more work for them to do. But someone will need to make the slides available to Nushin before Wednesday (possibly by posted them on our FTP) and send [redacted] the suggested questions for the Q&A, once the Secretary OK's them.

Happy Easter.

Brian

On Mon, Apr 10, 2017 at 5:40 PM, [redacted] <[redacted]gmail.com> wrote:

> Hi Brian, here is the deck the Secretary wants to use for the Studer CEO speech. The slide that says "VA is leading in Many areas", he would like to develop that slide a little bit more and get more input from the Under Secretaries and Deputy Under Secretaries.

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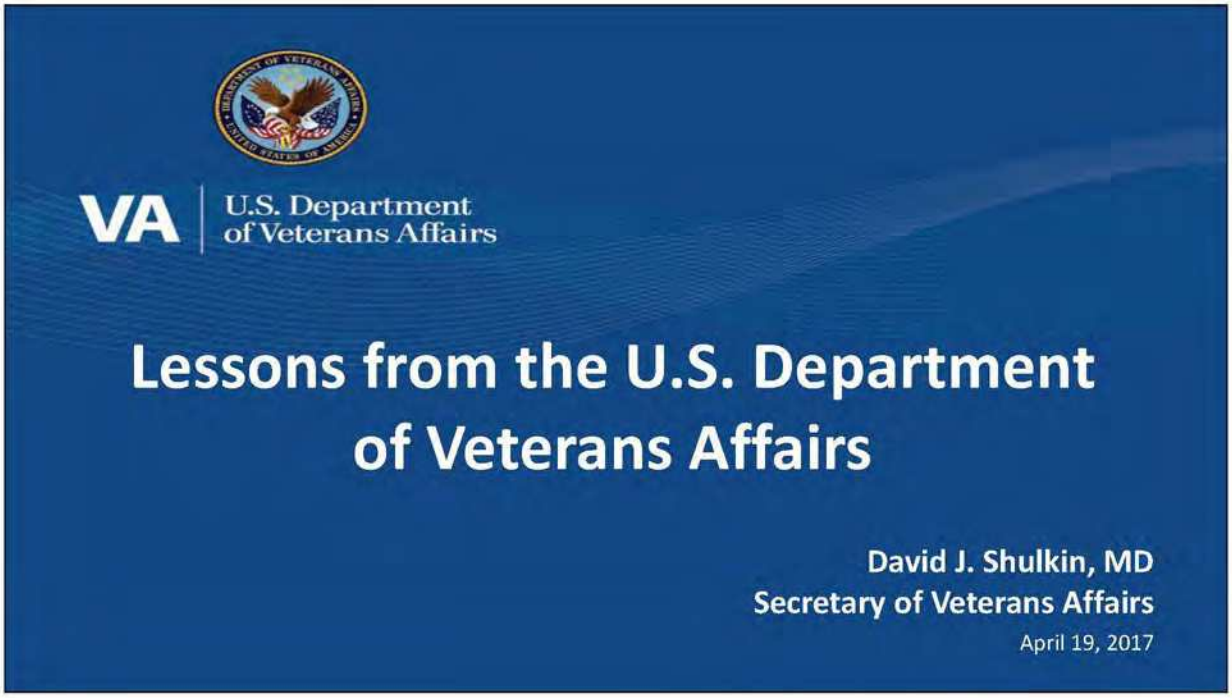

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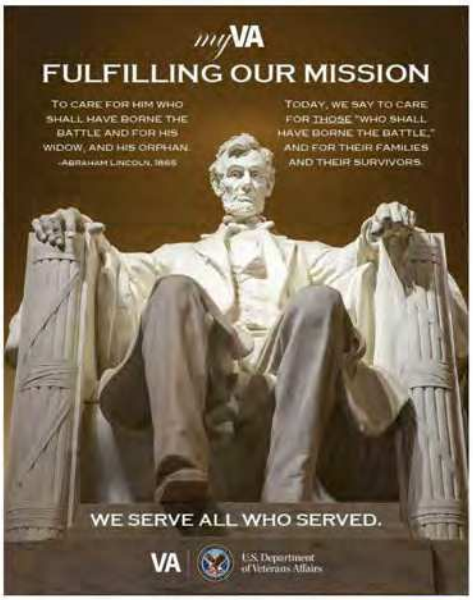

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High Performing Organizations



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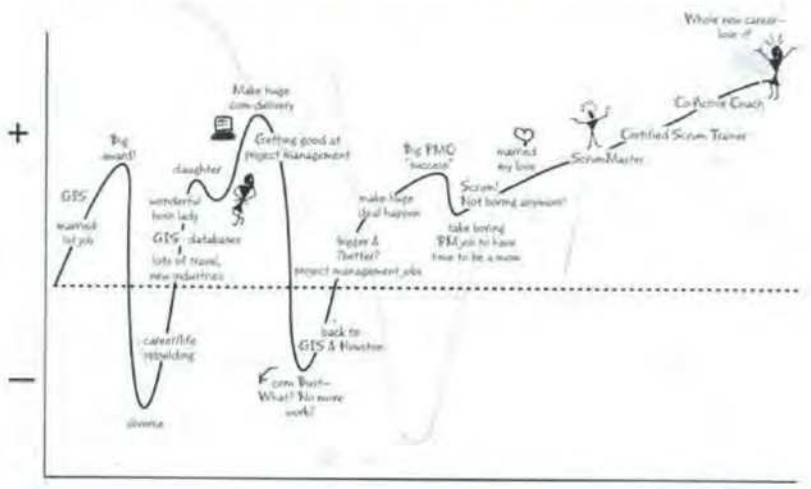
Share Your Journey



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Living With Purpose Is More Rewarding Than Meandering Around







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Paying Attention to Culture

'Final Salute' honors Holocaust survivor, Veteran



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Connect with Culture by Getting Out of the Office





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Learn Medicine on the Ski Slopes





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VA's Definition of Health

	Private Sector	Veterans Health Administration
Peer Support		X
Crisis Lines		X
Transportation		X
Caregivers		X
Homelessness Services		X
Medication Support		X
Behavioral Health Integration		X
Aligned Incentives		X
Lifelong Relationships		X
Single EMR Platform		X
Works with Most Leading Medical Centers		X
Vocational Support		X

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Leaders Ask the Right Questions

Two Things Every Leader Needs to Know:

- **Am I pushing too hard or not hard enough?**
- **What don't I know that is likely to damage the organization?**

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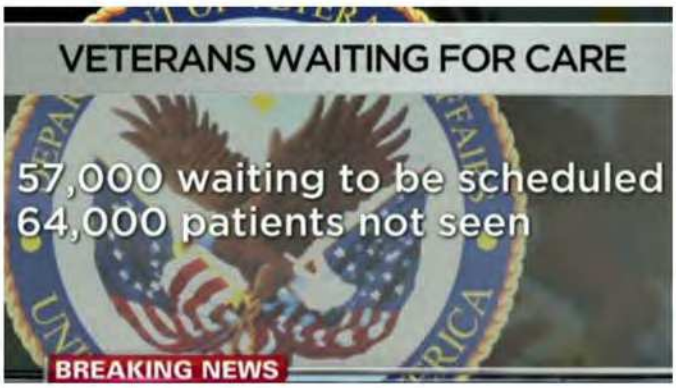
600,000 Veterans Waiting for Care?





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Focus on What's Important



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Set Big Goals



Talk to your Patient Aligned Care Team (PACT) or your Mental Health Team to learn about your options and timely access to care when you need it.

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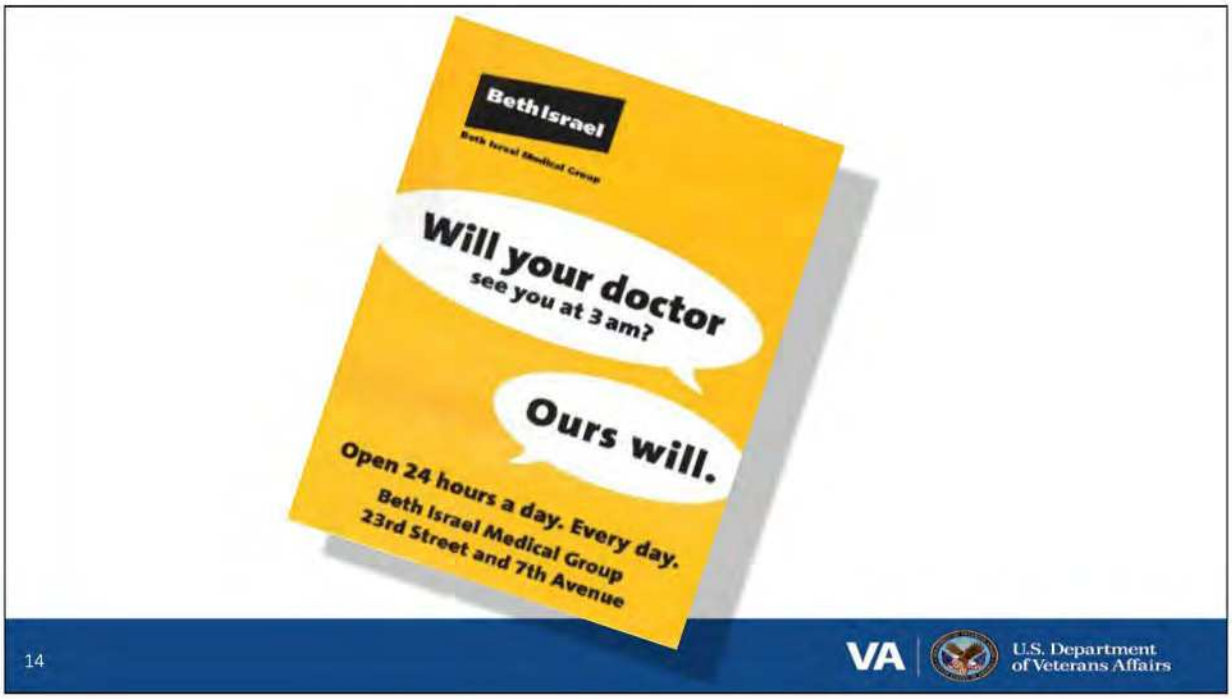

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Run Towards the Gun Fire





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Be Present



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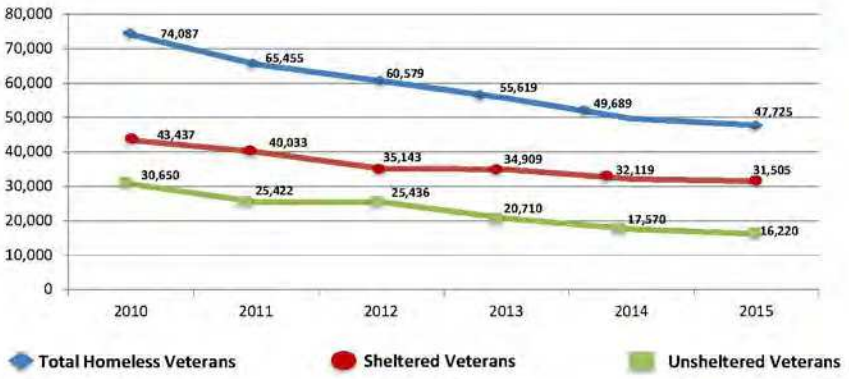
Decline in Homelessness



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Focus On Our People





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Barriers to Leadership



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Rid Organizations of Bad Actors (Stop Detailing)

"Dealing with employee issues
can be difficult,
but *not dealing with them*
can be worse."

- Paul Foster, CEO and Founder, The Business Therapist®

Business

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Accountability Legislation



Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Authority to **recoup bonuses** of employees for poor performance or misconduct.	Authority to **recoup relocation expenses** authorized through fraud or malfeasance.	Authority to **reduce federal pensions** for employees convicted of felonies.	Increased **protections for whistleblowers**.

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Little Stuff Matters





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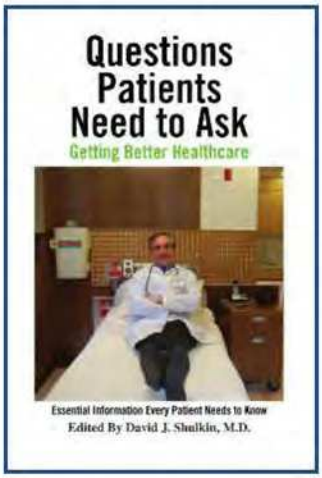
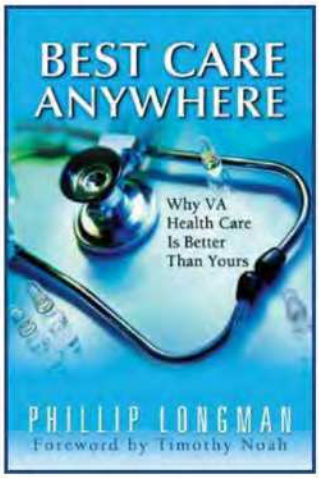
Get Everyone's Ideas





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Invest in Others and Develop Them



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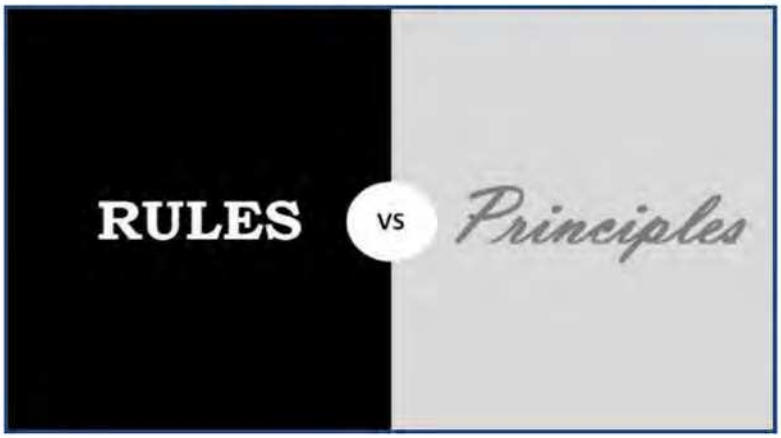
Principle vs. Rules Based Organizations





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This slide and the next two are examples of the services VA provides that the private sector often doesn't.

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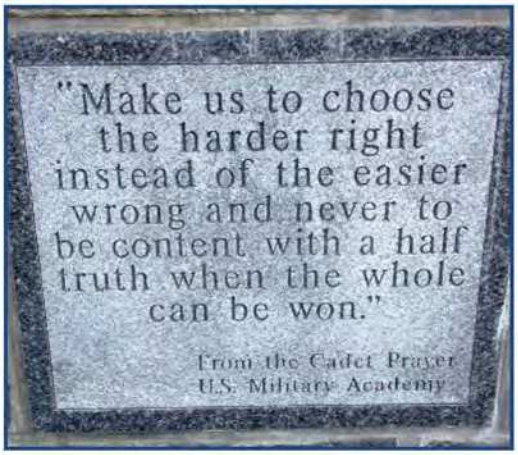
Choose the Harder Right Over the Easier Wrong





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Walking the Talk: Practicing in NY and Oregon





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Leaders Propose Solutions Rather Than Criticize



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Get People To Be Part of the Solution



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Challenge the Status Quo



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To Modernize, First Understand History



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VA Innovations



Barcoding of Medications



Nicotine Patches



First Liver Transplant



8 Lasker Awards



Cardiac Pacemaker



3 Nobel Prizes



Artificial Kidney



CT Scanner

AMERICAN OVERSIGHT

VA-19-0799-D-000557

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Center for Compassionate Innovation

To enhance Veterans health and well-being by offering safe and ethical therapies after traditional treatments have not been successful



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Making Tough Decisions



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APRNS – 300,000 Comments



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Effective Organizations Break Down Silos





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Don't Take No For An Answer



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"It takes an Act of Congress"



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VA is Leading In Many Areas

"Hospital-acquired infection is one of the country's leading causes of death, killing 75,000 people per year — more than car accidents and breast cancer combined. Yet hospitals have only started to take prevention seriously in the last decade, most in the last five years.

"One hospital group, however, has done more than all others. It's not the Mayo Clinic's hospitals, nor the Cleveland Clinic's, nor Kaiser Permanente, nor Sutter, nor Geisinger. These are all hospital chains known for their quality, but another big name leaves them in the dust: the V.A."

Tina Rosenberg
The New York Times

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Safety and Clinical Outcomes

- *JAMA*, February 2015: 30-day risk-adjusted mortality rates lower than those of non-VA hospitals for acute myocardial infarction and heart failure.
- *American Journal of Infection Control*: In five years, MRSA infections declined —
  - 81% in VA Spinal Cord Injury units (AJIC May 2013)
  - 69% in VA Acute Care facilities (AJIC Nov 2013)
  - 36% in VA Community Living Centers (AJIC Jan 2014)
- The Independent Assessment: VA performed the same or significantly better than non-VA providers on 12 of 14 effectiveness measures in the inpatient setting, significantly better on 16 outpatient HEDIS measures compared with commercial HMOs, and significantly better on 15 outpatient HEDIS measures compared with Medicare HMOs.
- A 2015 study published in the *Psychiatric Services*: VA mental health care was better than private-sector care by at least 30 percent on all seven performance measures, with VA patients with depression more than twice as likely as private-sector patients to get effective long-term treatment.
- A 2015 UC Davis study: Outcomes for VA patients compared favorably to patients with non-VA health insurance, with VA patients more likely to receive recommended evidence-based treatment.

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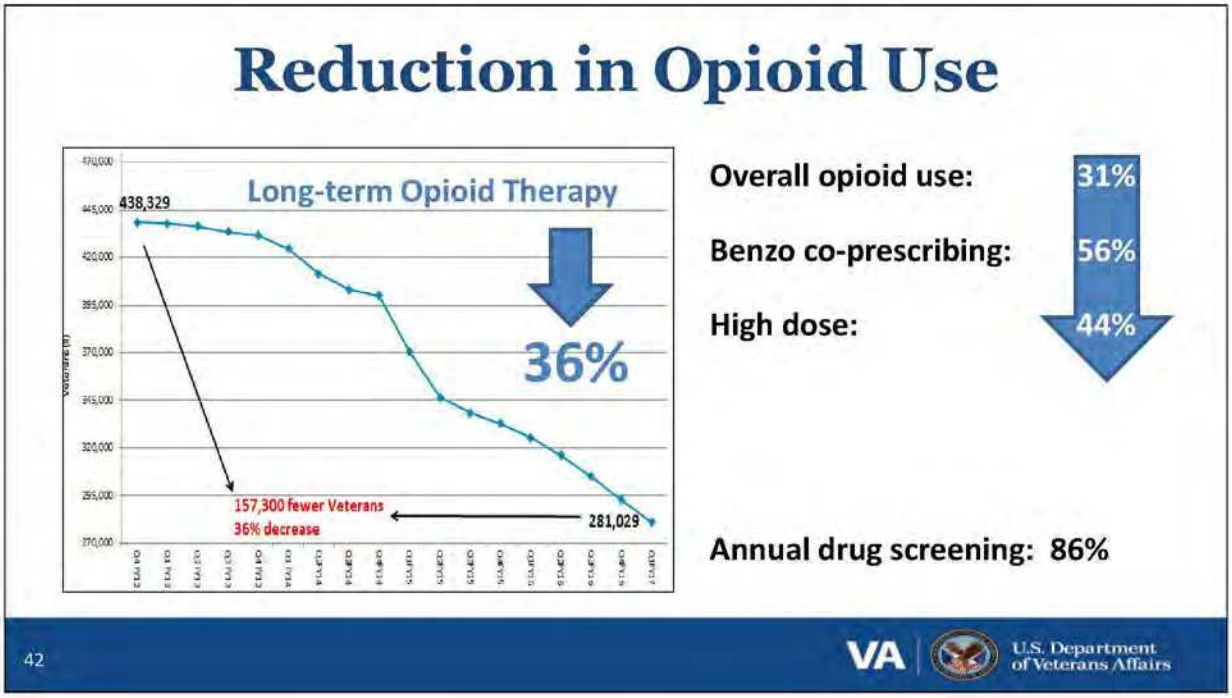

Decline in Veterans on long-term opioid therapy, 4Q FY 2012 to 1Q FY 2017. Overall opioid use down 31% in the same period.

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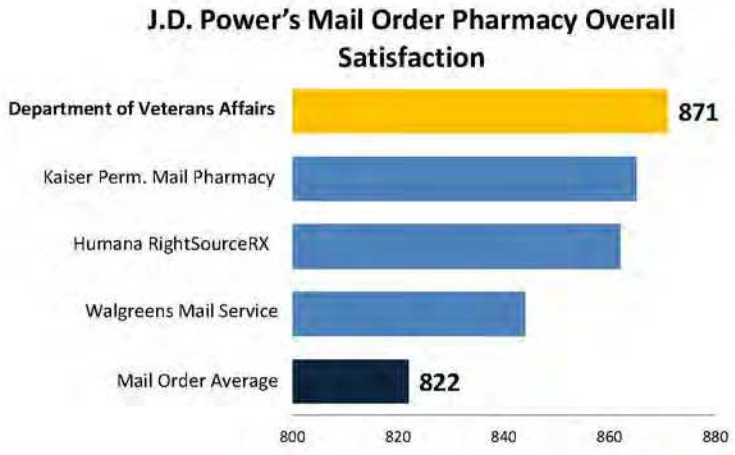
Our Pharmacy Is Best in Class



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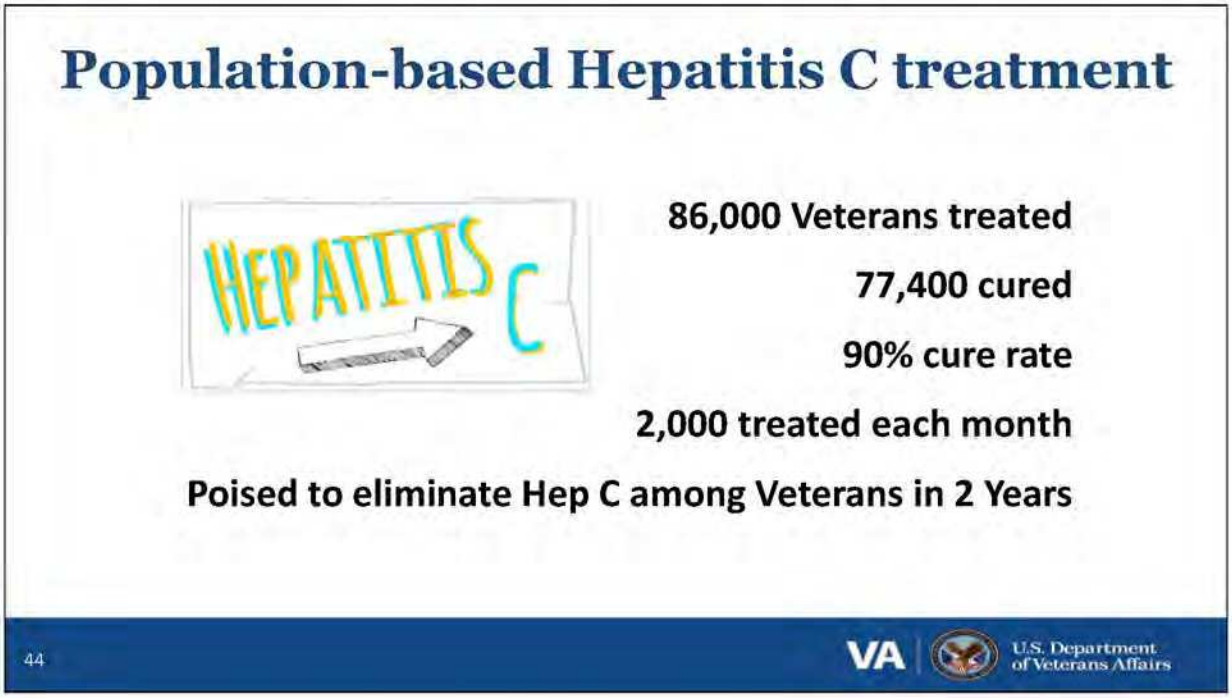

Decline in Veterans on long-term opioid therapy, 4Q FY 2012 to 1Q FY 2017. Overall opioid use down 31% in the same period.

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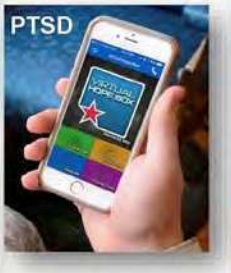
Specialists in Our Foundational Services











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Veterans Crisis Line

- 2.8 million calls answered since inception in 2007
- 2,000 life-changing calls answered daily
- 60 dispatches for emergency services daily
- 463,000 referrals made to local suicide prevention coordinators
- Calls rolled over to back-up centers cut from 3,000 in October to under 60 in January.
- Roll-over rate since January: Less than one percent.



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Innovative Research



- Almost 10,000 peer-reviewed studies published last year:
  - 1,800 on Access
    - 577 on PTSD
    - 386 on Suicide
    - 230 on TBI
- $680 million on research

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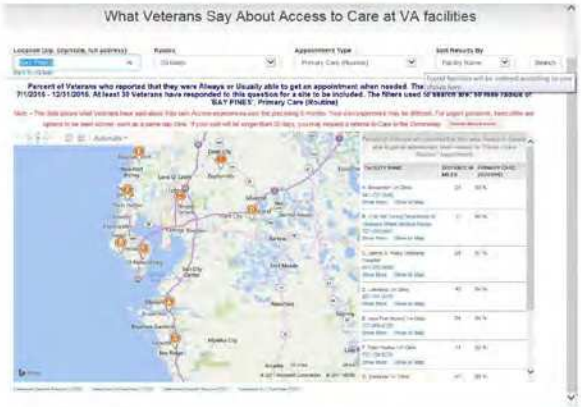
The Most Transparent

Wait times at local facilities



What Veterans are saying about access



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VA-19-0799-D-000573

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Largest Educator of Health Professionals

- Over 1,800 academic and institutional partners
- 120,000 healthcare workers trained each year:
  - ~ 60,000 medical students and residents
  - ~ 30,000 nursing students
  - ~ 30,000 students in other health fields
- An estimated 70% of all U.S. doctors have trained with VA.



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The Secretary's 5 Priorities

1. Greater Choice for Veterans

- Redesign the 40/30 Rule
- Build a High-Performing Integrated Network of Care
- Empower Veterans through transparency of information

2. Modernize our Systems

- Infrastructure Improvements and Streamlining
- EMR Interoperability and IT Modernization

3. Focus Resources More Efficiently

- Strengthening of Foundational Services in VA
- VA/DOD/Community Coordination
- Deliver on Accountability and Effective Management practices

4. Improve Timeliness of Services

- Access to Care and Wait Times
- Decisions on Appeals
- Performance on Disability Claims

5. Suicide Prevention

- Getting to Zero



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Huron CEO Forum
Sofitel, Washington, DC
April 19, 2017

Huron is a global professional services firm committed to achieving sustainable results in partnership with our clients. We bring a depth of expertise in strategy, operations, advisory services, technology and analytics to drive lasting and measurable results in the healthcare, higher education, life sciences and commercial sectors. Through focus, passion and collaboration, Huron provides guidance to support organizations as they contend with the change transforming their industries and businesses.

- The audience will consist of 32 healthcare CEOs (see list below), plus a dozen or so Huron managers.
- Huron Managers [(b) (6)] and [(b) (6)] will meet you upon your arrival.
- [(b) (6)] Huron Managing Director, will introduce you. See bio below.
- You will speak from a podium with a Lavalier mic and confidence monitor.
- You have been allotted one hour (3:45 to 4:45) for remarks and Q&A with [(b) (6)] CEO, Carilion Clinic in Roanoke, VA.

Run of Show:

3:30-3:45	Break
3:45-4:45	You speak and then answer questions
5:00	Program ends

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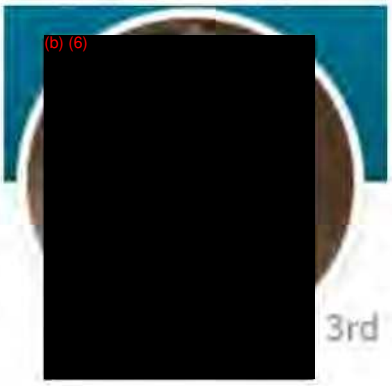
(b) (6) Managing Director, Huron Consulting, has more than 26 years of experience helping large health systems, academic medical centers, children's hospitals and large physician groups to substantially improve their operational and financial performance. (b) (6) is a member of the Huron Healthcare senior executive team, providing leadership for the strategic direction and operations of the practice. His leadership role includes responsibility for strategy, marketing, and strategic relationships in addition to his role leading large, complex client engagements.

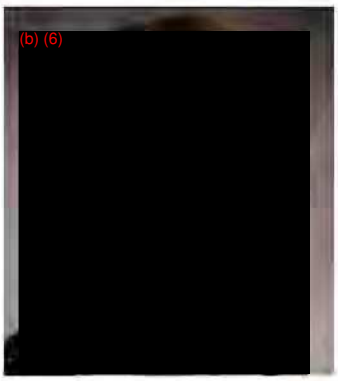


In 1995, (b) (6) joined Stockamp & Associates, which was acquired by Huron Consulting Group in 2008, and held various leadership positions within Stockamp over his 15 years with the company. Prior to joining Stockamp, (b) (6) had a successful nine-year consulting career at Booz Allen & Hamilton and at Accenture.

Prior to leading the Strategy, Marketing and Sales operations at Stockamp, (b) (6) led the firm's Western U.S. operations. In this role he had overall responsibility for Stockamp's client engagements, client relationships, strategic sales pursuits and strategy in the western half of the United States.

(b) (6) has worked with over 100 hospitals, health systems and academic medical centers, helping them to realize millions of dollars in financial benefits and implementing improvements in healthcare operations and IT-enabled solutions. He has a BS in economics from Oregon State University.

(b) (6) President and CEO of Carilion Clinic, a not–for–profit healthcare organization based in Roanoke, Va., providing care close to home for nearly 1 million Virginians.



Born at Roanoke Memorial Hospital, Ms. (b) (6) began her career in nursing in the early 1970s, serving in various management roles over the years. In 1996, she was appointed vice president and gradually assumed increasing administrative and executive leadership roles at Carilion. As Executive Vice President and Chief Operating Officer from 2001 to 2011, Ms. (b) (6) was at the forefront of the successful initiative to reorganize Carilion into a patient-centered, physician-led clinic.

She supports many professional and community activities including board positions for The American Hospital Association, The Joint Commission, Virginia Hospital and Healthcare Association, Virginia Center for Health Innovation, Roanoke Gas Company, HomeTown Bank, Virginia Tech Carilion School of Medicine, Rockingham Mutual Insurance Co. and the Taubman Museum of Art. Previously, Ms. (b) (6) served on the Radford University Board of Visitors.

Ms. (b) (6) and her husband, (b) (6) have one son, (b) (6)

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Registered Attendees

(b) (6)	
[redacted]	SoutheastHEALTH
	Sentara Healthcare
	CHI St. Luke's Health
	VCU Health
	FMOL Health System
	Hartford HealthCare
	Woman's Hospital
	UI Health
	UW Medicine
	Benefis Health System
	Atlantic Health System
	Northwestern Memorial HealthCare
	Holyoke Medical Center
	Spartanburg Regional Healthcare System, Apella Health, and Guardian Research Network
	Hartford HealthCare
	Virginia Mason Medical Center
	Sentara Healthcare
	Mosaic Life Care
	Carle Health System
	TBD
	Visiting Nurse Service of New York
	Dignity Health
	UNC Hospitals
	NA
	Navicent Health
	Bon Secours Health System
	Orlando Health, Inc.
	Marshfield Clinic Health System, Inc.
	NEW

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/8/2017 8:14:57 PM
To: (b) (6) [redacted]gmail.com
Subject: draft for studer group
Attachments: studer2017.pptx

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Lessons from the US Department of Veterans Affairs

David J. Shulkin MD

The 9th Secretary of US Department of Veterans Affairs

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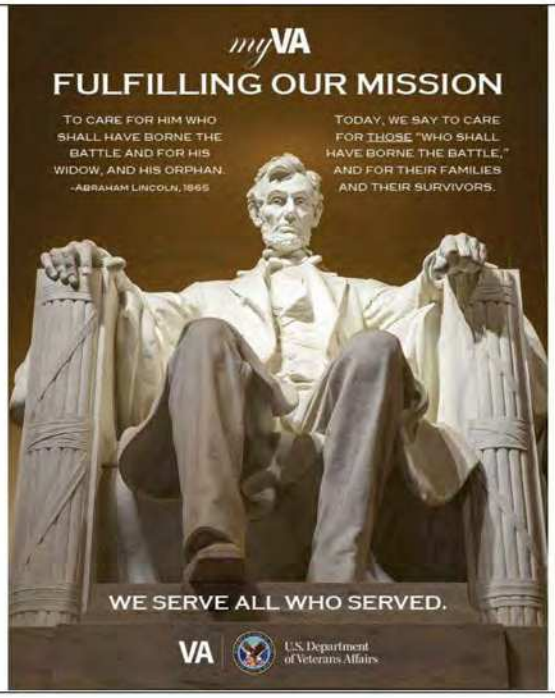

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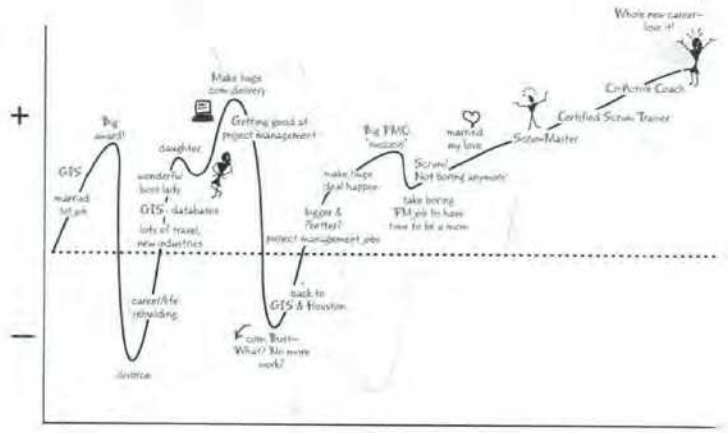
Share Your Journey



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Living with purpose is more rewarding than meandering around







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Pay Attention to Culture

'Final Salute' honors Holocaust survivor, Veteran



Sailors wait in a hallway on the medical-surgical floor in Lovell FHCC for the body of Holocaust survivor and Korean War Air Force Veteran Paul Argiewicz to be wheeled to the elevators. (Photos by Trevor Scelia)

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Understand Culture By Getting Out of the Office





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Learning Medicine on the Ski Slopes





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VA's Definition of Health

	Private Sector	Veterans Health Administration
Peer Support		X
Crisis Lines		X
Transportation		X
Caregivers		X
Homelessness Services		X
Medication Support		X
Behavioral Health Integration		X
Aligned Incentives		X
Lifelong Relationships		X
Single EMR Platform		X
Works with Most Leading Medical Centers		X
Vocational Support		X

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Ask the Right Questions
Two Things Every Leader Needs to Know

- Am I pushing too hard or am I not pushing hard enough?

- What don't I know that is likely to damage the organization?

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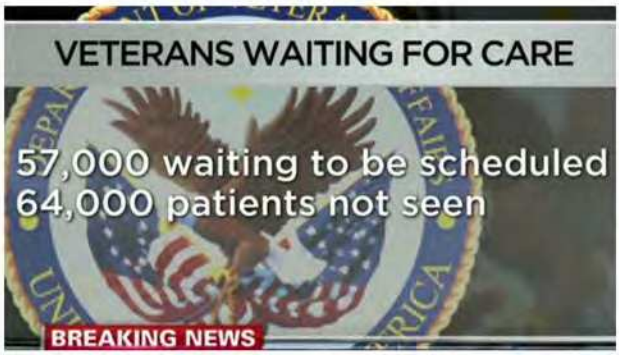
Asking About 600,000 Veterans Waiting for Care





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FOCUS ON WHAT IS IMPORTANT



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Set Big Goals



Talk to your Patient Aligned Care Team (PACT) or your Mental Health Team to learn about your options and timely access to care when you need it.

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Run Towards the GunFire





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Be Present



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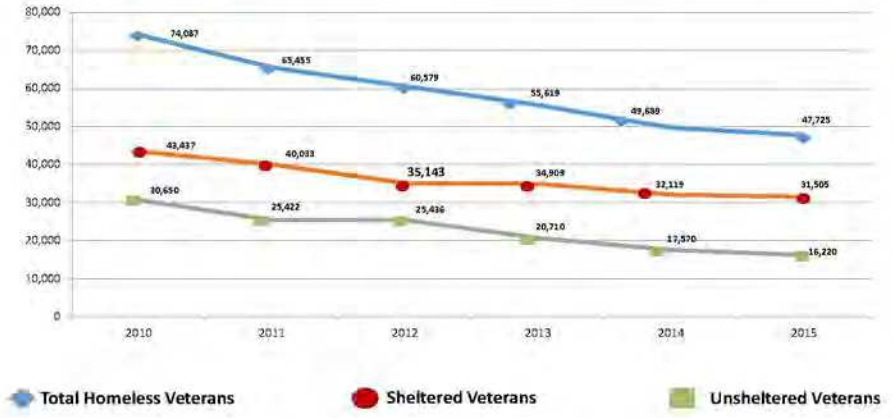
Decline in Homelessness





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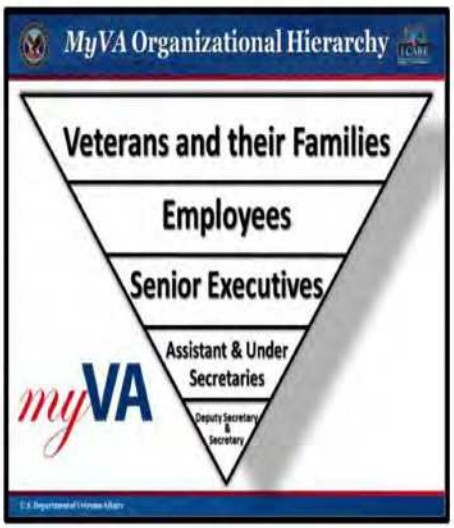
Focus on Our People





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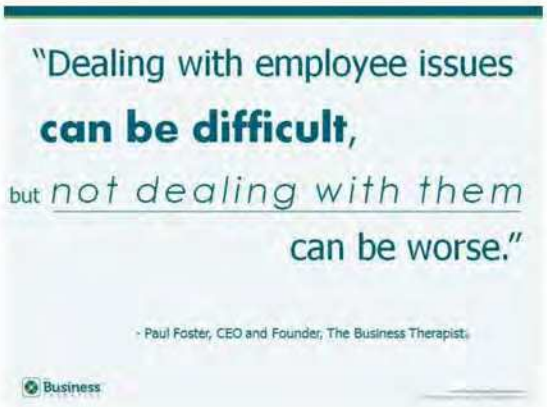
Rid Organizations of Bad Actors (Stop the Detailing)



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Accountability Legislation



Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Authority to **recoup bonuses** of employees for poor performance or misconduct.	Authority to **recoup relocation expenses** authorized through fraud or malfeasance.	Authority to **reduce federal pensions** for employees convicted of felonies.	Increased **protections for whistleblowers**.

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Little Stuff Matters

Thank You



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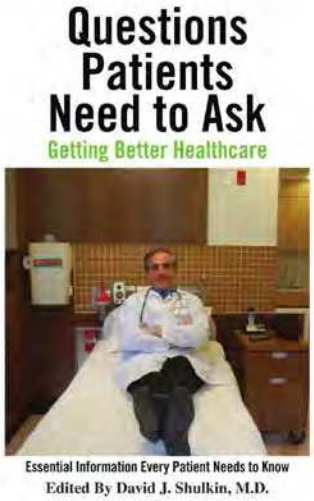
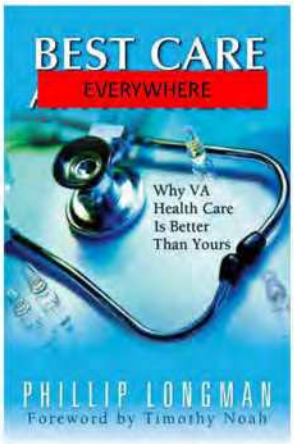
Get Everyone's Ideas





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Invest in others and develop them



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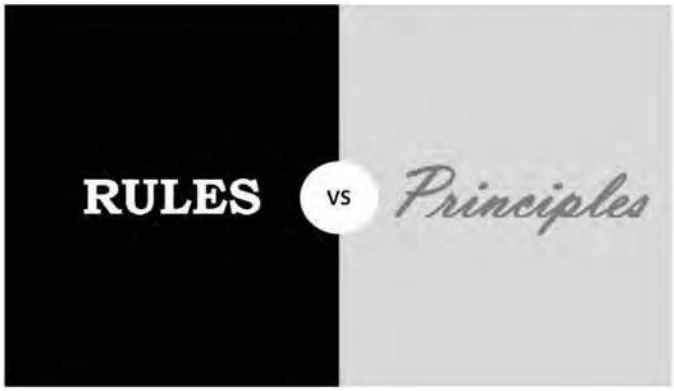
Principle Based (vs. Rules Based) Organizations





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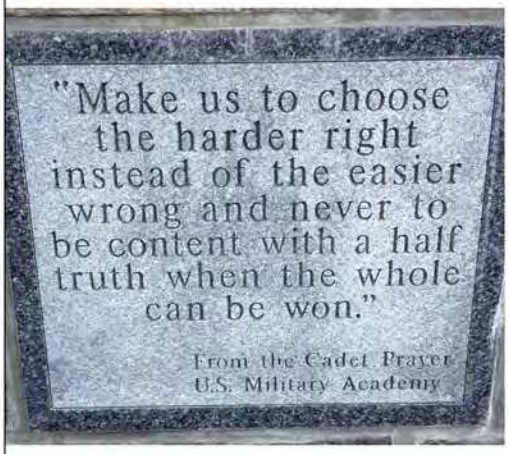
Choose the Hard Right than the Easier Wrong





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Walk the Talk-Practicing in NY and Oregon





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Leaders Propose Solutions , not Criticize



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Getting People to Be Part of the Solution



On February 2, 2016, VA hosted a summit, "Preventing Veterans Suicide – A Call to Action" to bring together Veterans, families, federal agencies, community providers, subject matter experts, and other key stakeholders to enhance suicide prevention efforts.

The summit generated a new framework for VA's approach to Suicide Prevention that will transform the vision and structure of suicide prevention across VA and the community.

VA has elevated and expanded our Suicide Prevention Program to fulfill this vision, which includes:

Meeting urgent mental health needs by providing Veterans same-day evaluations and access by the end of calendar year 2016.

Building and leveraging strategic partnerships to disseminate new initiatives within VA and to reach non-VA using Veterans.

Development and implementation of innovative life-saving programs, such as REACH-VET, which uses predictive modeling to identify Veterans at high risk for suicide.

Continuing to partner with the Department of Defense for a seamless transition from military service to civilian life.

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Challenge the Status Quo



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Innovations from VA



First Liver Transplant


CT Scanner


Artificial Kidney


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Don’t take no for an answer



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"It takes an Act of Congress"

38

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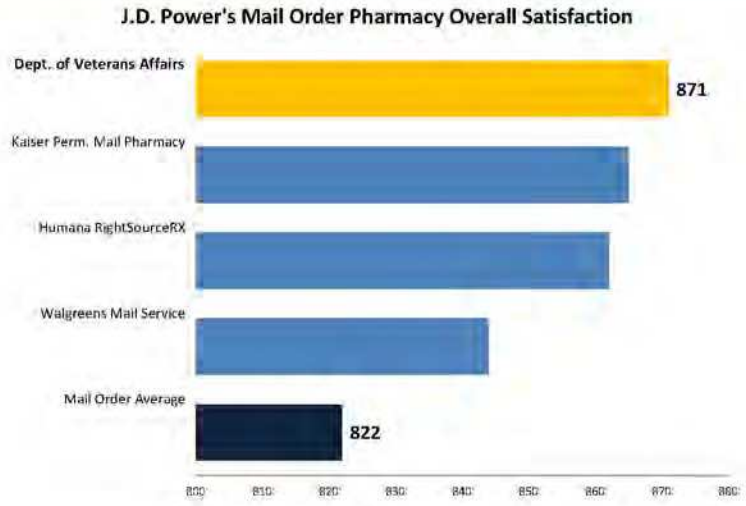
Our Pharmacy is best in class



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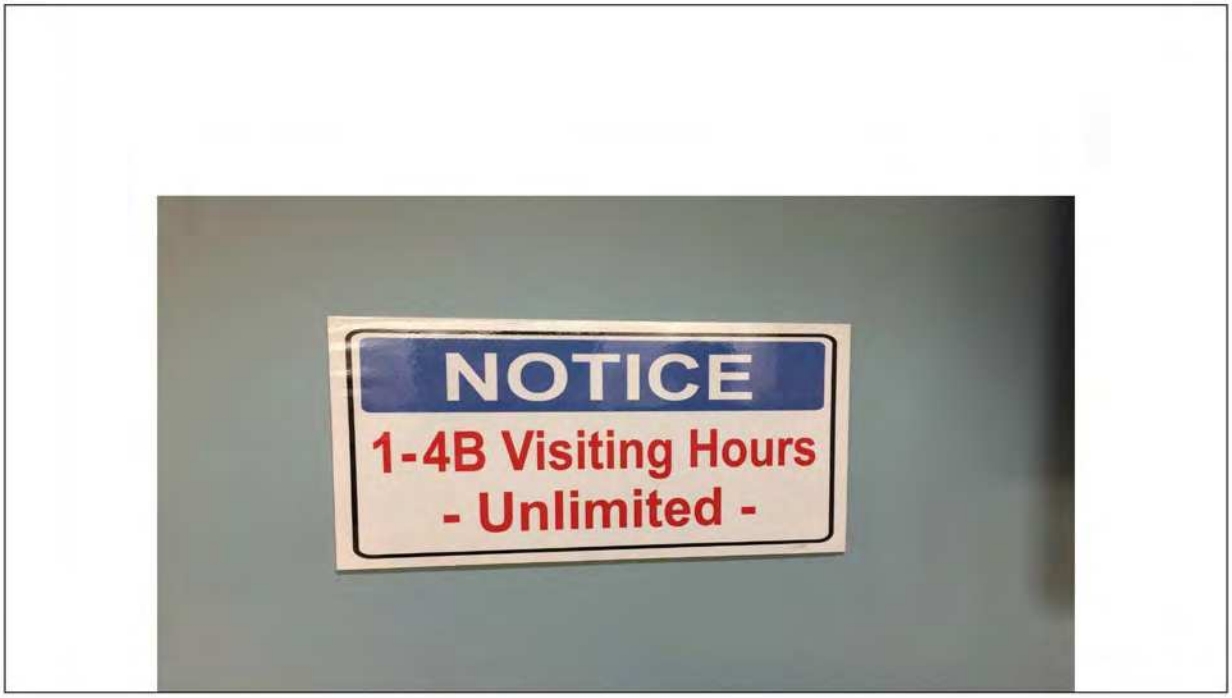

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VA is Leading In Many Areas

- Safety and Clinical Outcomes as good or Better than Private Sector
- Opioid Reduction of > 30%
- Population Based Hepatitis C Treatment
- Largest educator of health professionals in US
- Over 10,000 peer reviewed studies published last year
- More than 2000 veteran crisis line calls are addressed each day

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The Secretary's 5 Priorities

- Greater Choice for Veterans
  - -Revise the 40/30 Rule
  - -Build an Integrated Network of Care
  - - Empower veterans through transparency of information
- Modernize our System
  - -Infrastructure Improvements and Consolidations
  - -EMR Interoperability and Modernization
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  - -Deliver on Accountability and Effective Management practices
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  - - Wait times and Accessibility for Care
  - - Decisions on Appeals
  - - Performance on Disability Claims
- Suicide Prevention

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Thank You



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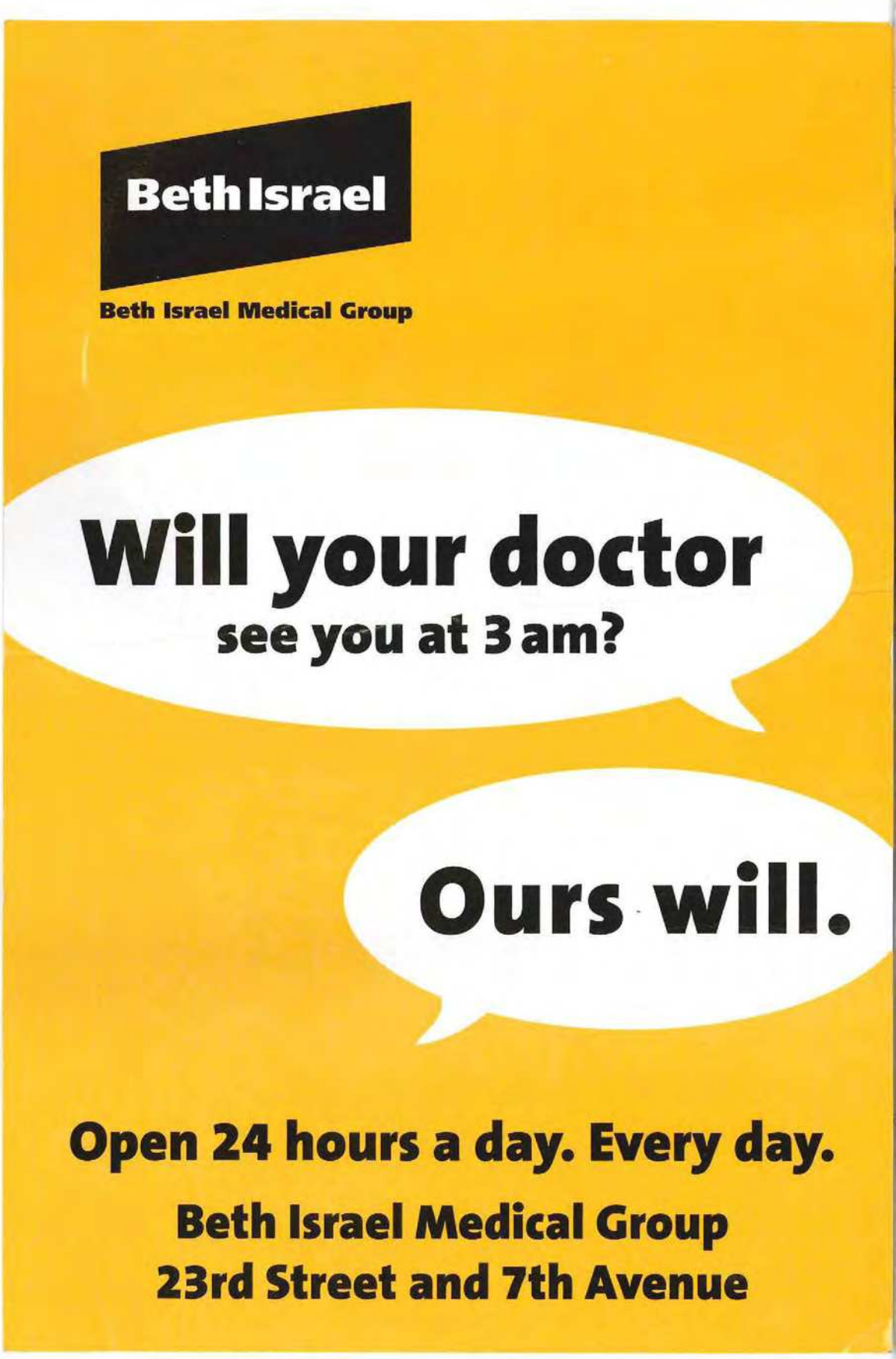

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/15/2017 10:49:30 PM
To: (b) (6) [redacted]gmail.com
Subject: slides for huron
Attachments: huronupdated.pptx

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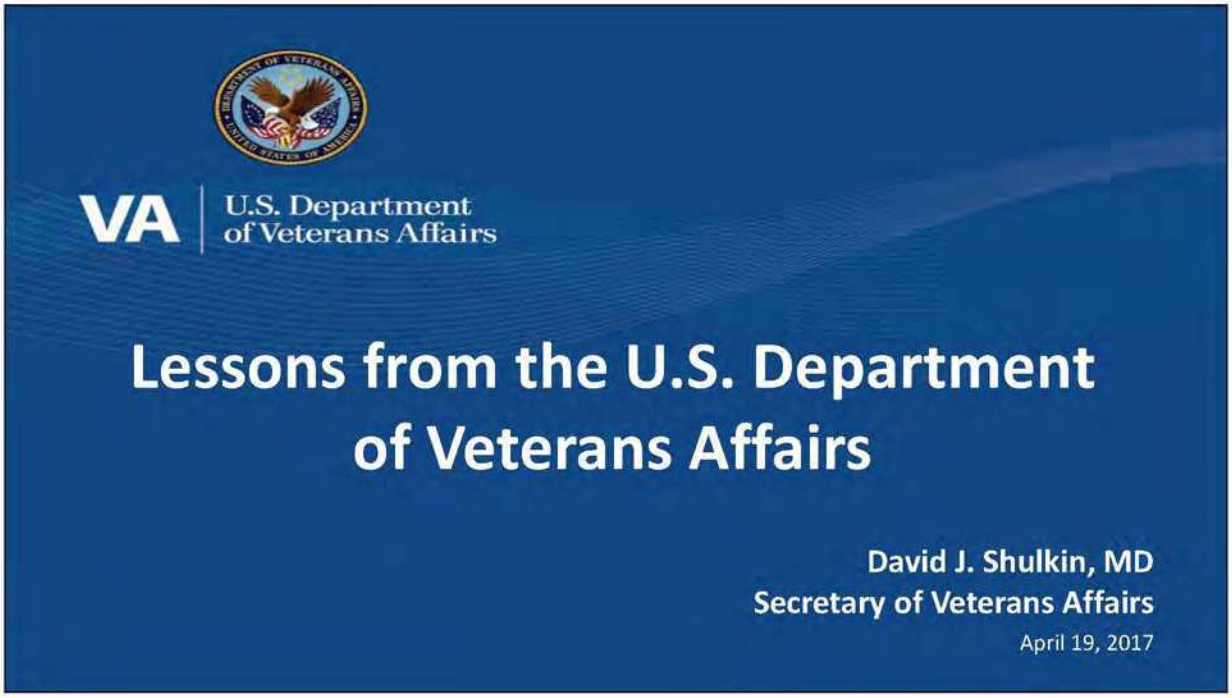

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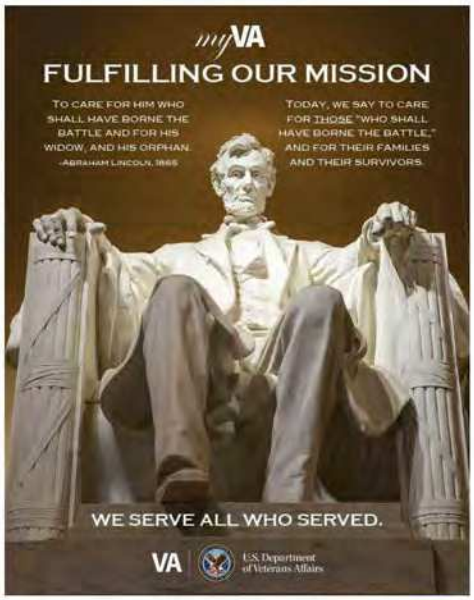

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Largest Educator of Health Professionals

- Over 1,800 academic and institutional partners
- 120,000 healthcare workers trained each year:
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  - ~ 30,000 students in other health fields
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CT Scanner

AMERICAN OVERSIGHT

VA-19-0799-D-000629

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Current Research



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  - 577 on PTSD
  - 386 on Suicide
  - 230 on TBI
- $680 million on research

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Important Contributions to Society



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High Performing Organizations



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Living With Purpose Is More Rewarding Than Meandering Around







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Paying Attention to Culture

'Final Salute' honors Holocaust survivor, Veteran



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Connect with Culture by Getting Out of the Office





AMERICAN OVERSIGHT

Learn Medicine on the Ski Slopes





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VA's Definition of Health

	Private Sector	Veterans Health Administration
Peer Support		X
Crisis Lines		X
Transportation		X
Caregivers		X
Homelessness Services		X
Medication Support		X
Behavioral Health Integration		X
Aligned Incentives		X
Lifelong Relationships		X
Single EMR Platform		X
Works with Most Leading Medical Centers		X
Vocational Support		X

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Leaders Ask the Right Questions

Two Things Every Leader Needs to Know:

- **Am I pushing too hard or not hard enough?**
- **What don't I know that is likely to damage the organization?**

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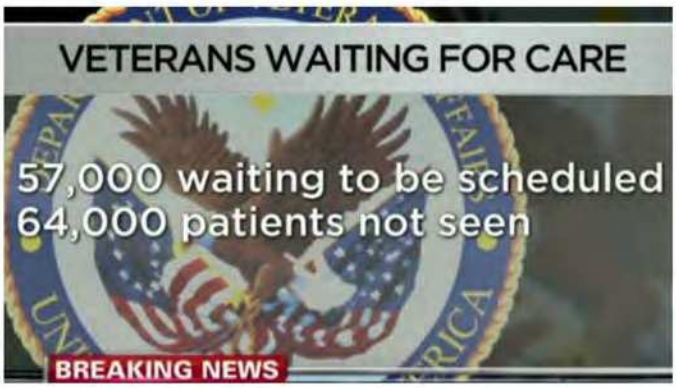
600,000 Veterans Waiting for Care?





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Focus on What's Important



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AMERICAN OVERSIGHT

Creating Sustainability



Talk to your Patient Aligned Care Team (PACT) or your Mental Health Team to learn about your options and timely access to care when you need it.

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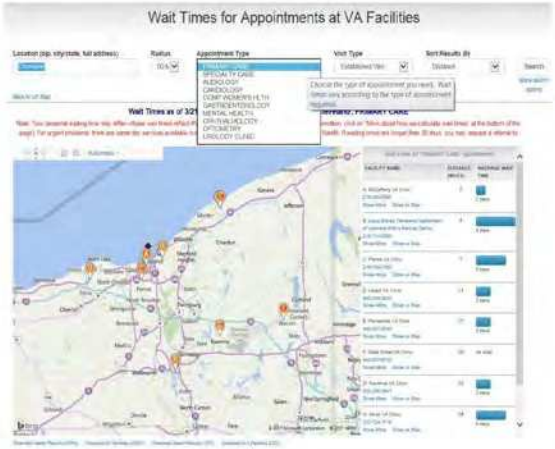
Wait times at local facilities



What Veterans are saying about access



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Run Towards the Gun Fire





AMERICAN OVERSIGHT

Being Present



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Focus On Our People





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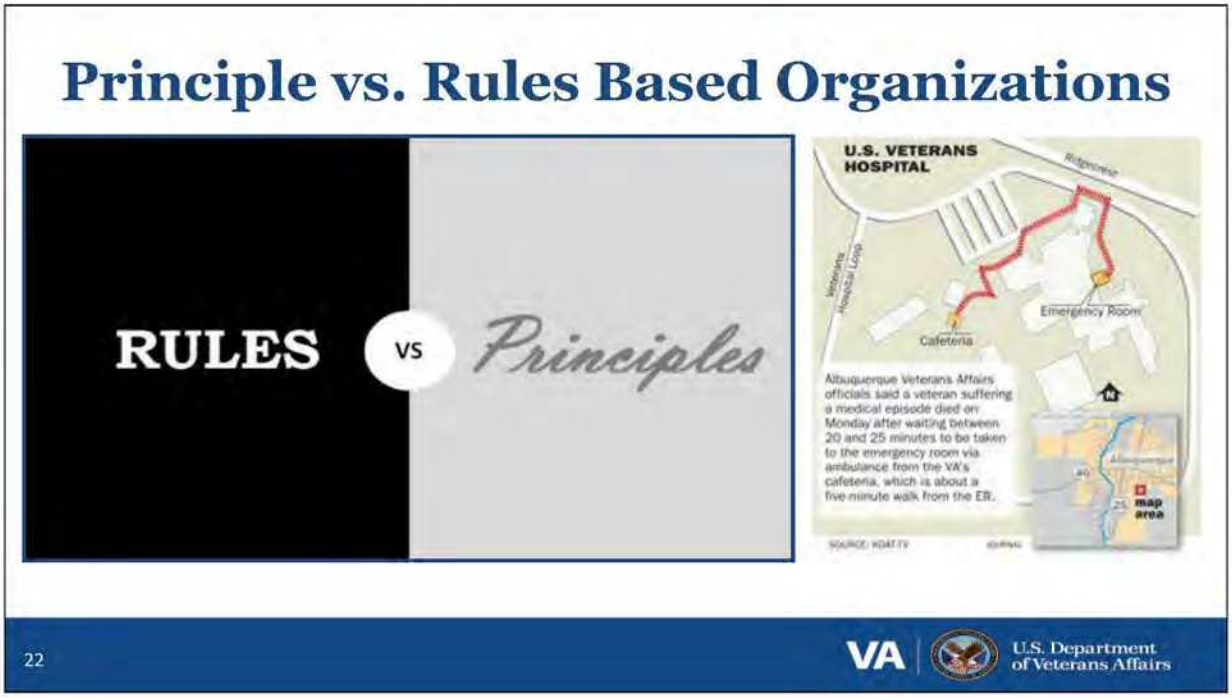
Rid Organizations of Bad Actors (Stop Detailing)

"Dealing with employee issues
can be difficult,
but *not dealing with them*
can be worse."

- Paul Foster, CEO and Founder, The Business Therapist®

Business

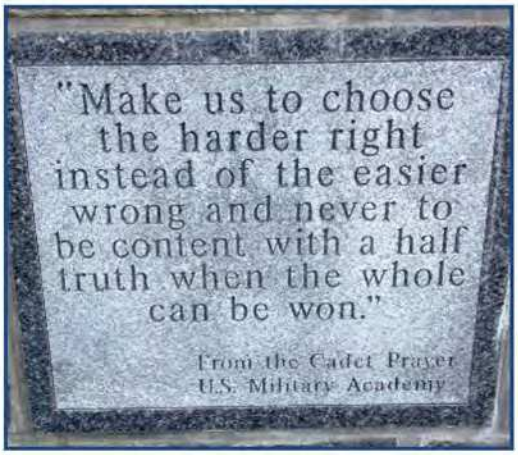
AMERICAN OVERSIGHT



This slide and the next two are examples of the services VA provides that the private sector often doesn't.

AMERICAN OVERSIGHT

Choose the Harder Right Over the Easier Wrong





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My Board



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Get People To Be Part of the Solution



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Making Tough Decisions



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APRNS – 300,000 Comments



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Challenge the Status Quo



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Center for Compassionate Innovation

To enhance Veterans health and well-being by offering safe and ethical therapies after traditional treatments have not been successful



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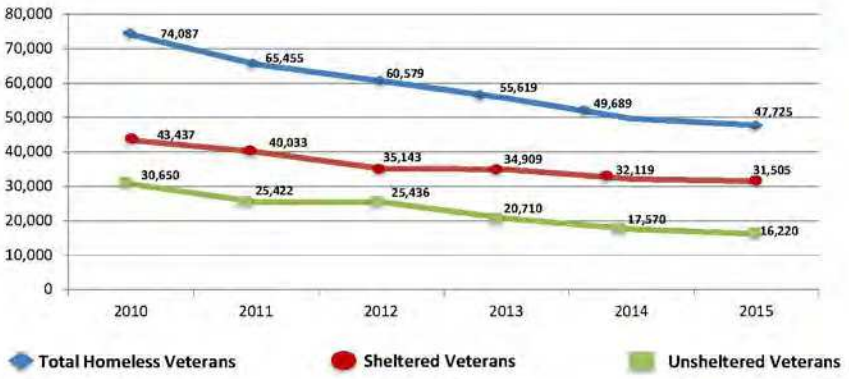
Effective Organizations Break Down Silos





AMERICAN OVERSIGHT

Decline in Homelessness





VA U.S. Department of Veterans Affairs

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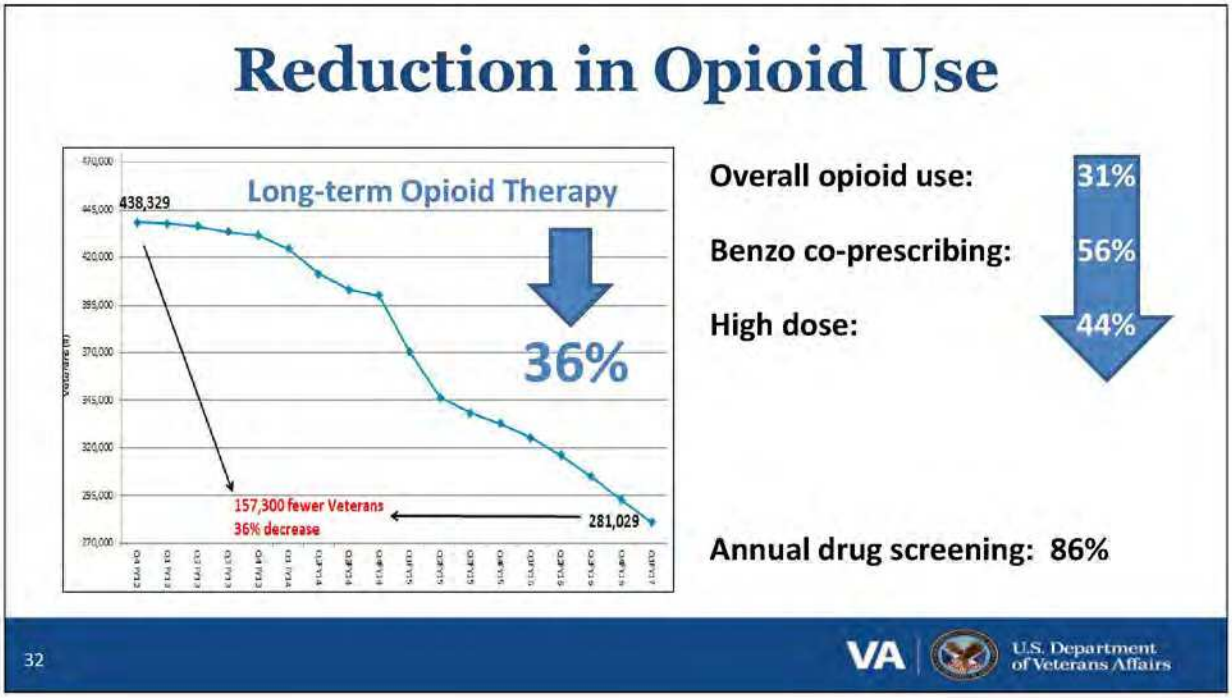
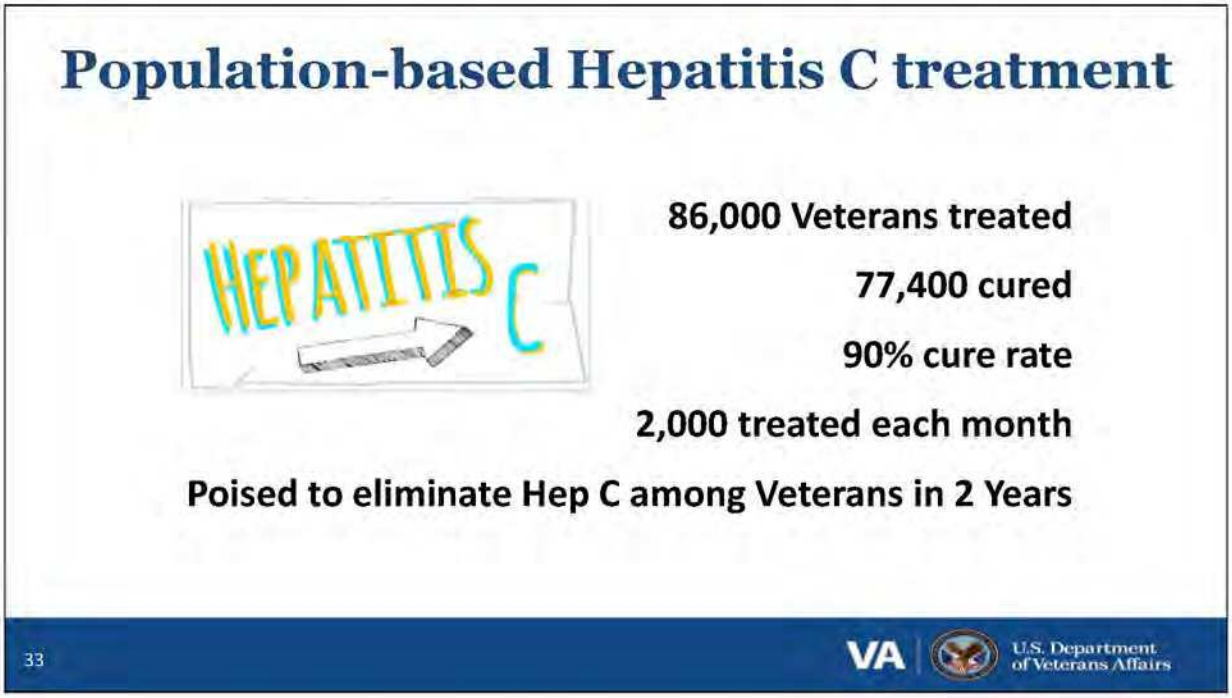


Decline in Veterans on long-term opioid therapy, 4Q FY 2012 to 1Q FY 2017. Overall opioid use down 31% in the same period.

AMERICAN OVERSIGHT



Decline in Veterans on long-term opioid therapy, 4Q FY 2012 to 1Q FY 2017. Overall opioid use down 31% in the same period.

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The Secretary's 5 Priorities

1. Greater Choice for Veterans
2. Modernize our Systems
3. Focus Resources More Efficiently
4. Improve Timeliness of Services
5. Suicide Prevention



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Greater Choice for Veterans

- Redesign the 40/30 Rule to use clinical criteria for

  veteran choice
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information

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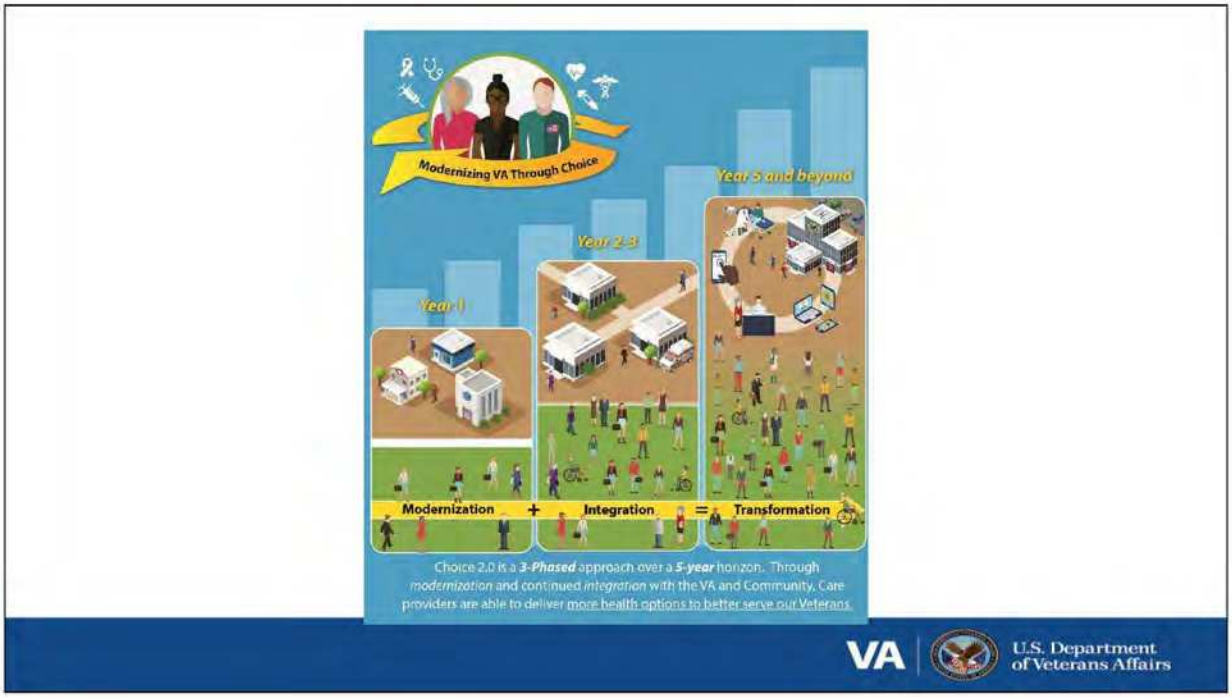
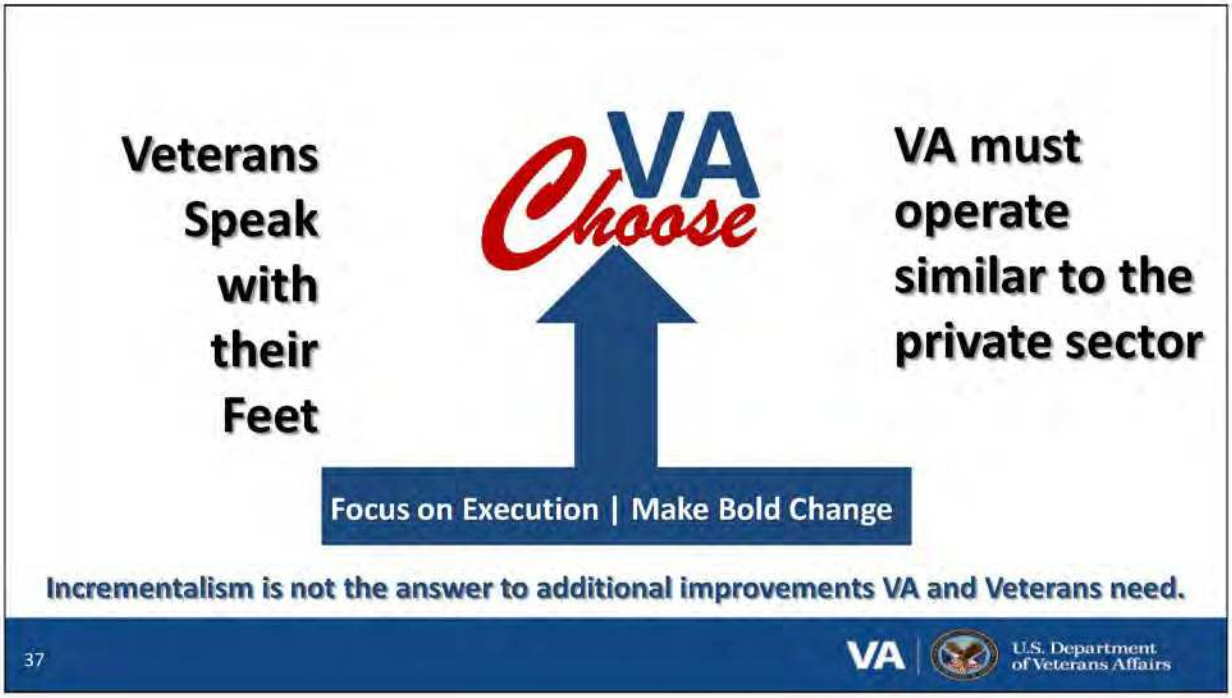


AMERICAN OVERSIGHT



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Modernize Our Systems

- Infrastructure improvements and streamlining services
- EMR interoperability and IT modernization

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Infrastructure Improvements



Officers' Quarters
Fort Thomas, KY
Circa 1895



Gas Station
Minneapolis, MN
1932



Palo Alto VAMC
2017

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Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

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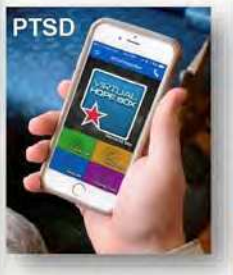
World Class Foundational Services











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AMERICAN OVERSIGHT

Accountability Legislation



Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Authority to **recoup bonuses** of employees for poor performance or misconduct.	Authority to **recoup relocation expenses** authorized through fraud or malfeasance.	Authority to **reduce federal pensions** for employees convicted of felonies.	Increased **protections for whistleblowers**.

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Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

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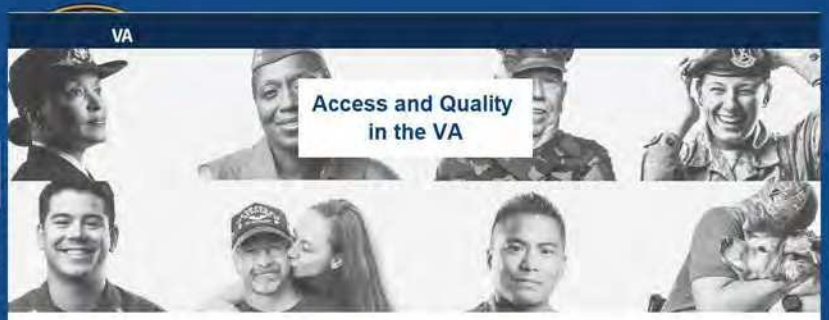
VA



How quickly does my VA see patients?

How satisfied are veterans like me with the timeliness of their care?

How well does my VA's care compare to other hospitals?

VA Pre-Decisional

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5- Suicide Prevention



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Priority 8- Suicide Prevention



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Thank You



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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/16/2017 1:19:27 AM
To: Vivieca Simpson [(b) (6) gmail.com]

Vivieca- if i wanted to ask about a wolftrap show - who is best to ask?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/13/2017 4:08:28 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Jen

Of course

Sent from my iPhone

> On Apr 13, 2017, at 11:38 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> I want to give it to Lu Beck instead of Mike Valentino- you OK?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/13/2017 3:38:08 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Jen

I want to give it to Lu Beck instead of Mike Valentino- you OK?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/19/2017 10:22:07 PM
To: David Shulkin [drshulkin@aol.com]
Subject: health data palooza options
Attachments: healthdatapoolza-Shulkin.pptx; LPW Healthdata Palooza.pptx; 2017 04 28-1 Health Datapalooza.pdf

Hi,

the first deck is yours.

the second deck is mine -recommendations , not fully edited, just wanted to show you a story before I edited down

the second deck is the deck brian created from your suggestions

talk is only 15 minutes. Can edit more if you choose.

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Health Datapalooza

David Shulkin, M.D.
Secretary
Department of Veterans Affairs

U.S. Department of Veterans Affairs

AAMC 11/6/15

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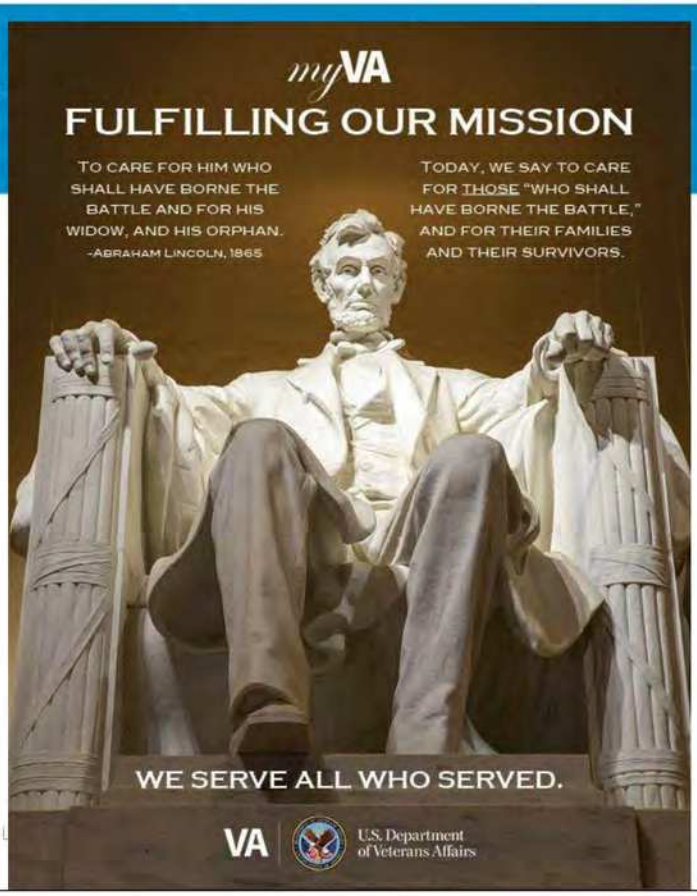

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Great Tradition: Honoring Those Who Served

'Final Salute' honors Holocaust survivor, Veteran



Sailors wait in a hallway on the medical-surgical floor at Lowell FHCC for the body of Holocaust survivor and Korean War Air Force Veteran Paul Argiewicz to be wheeled to the elevators. (Photos by Trevor Stula)

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VA-19-0799-D-000679

DS_00002348

Delivering Care Where We Don't Have Facilities





VETERANS HEALTH ADMINISTRATION

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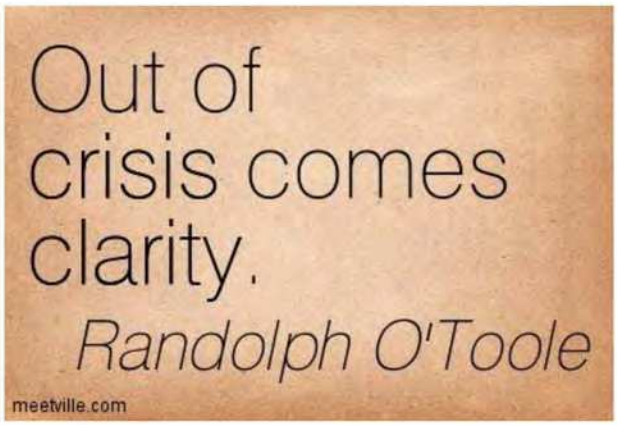
Crisis to Clarity



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VA-19-0799-D-000681

DS_00002350

VA Needs Partners and Technology



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That's My Ear!



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VA Telehealth Services

2.14 million episodes to 677,000 Veterans (12%)



Home Telehealth
156,000 Veterans



Video Telehealth
282,000 Veterans

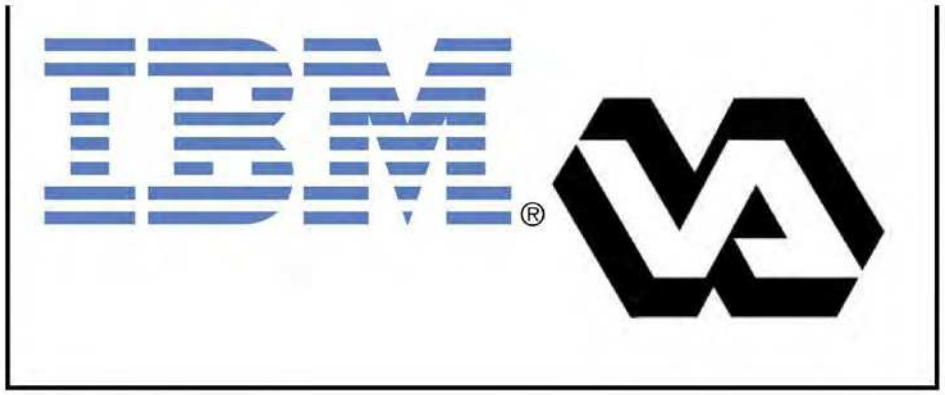


Store-and-Forward Telehealth
298,000 Veterans

45% of our Telehealth services are for rural Veterans

AMERICAN OVERSIGHT

IBM Watson Health



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Predictive Analytics in Issues that Are Critical to Veterans



- **Oncology**
- **PTSD**
- **TBI**
- **Suicide**

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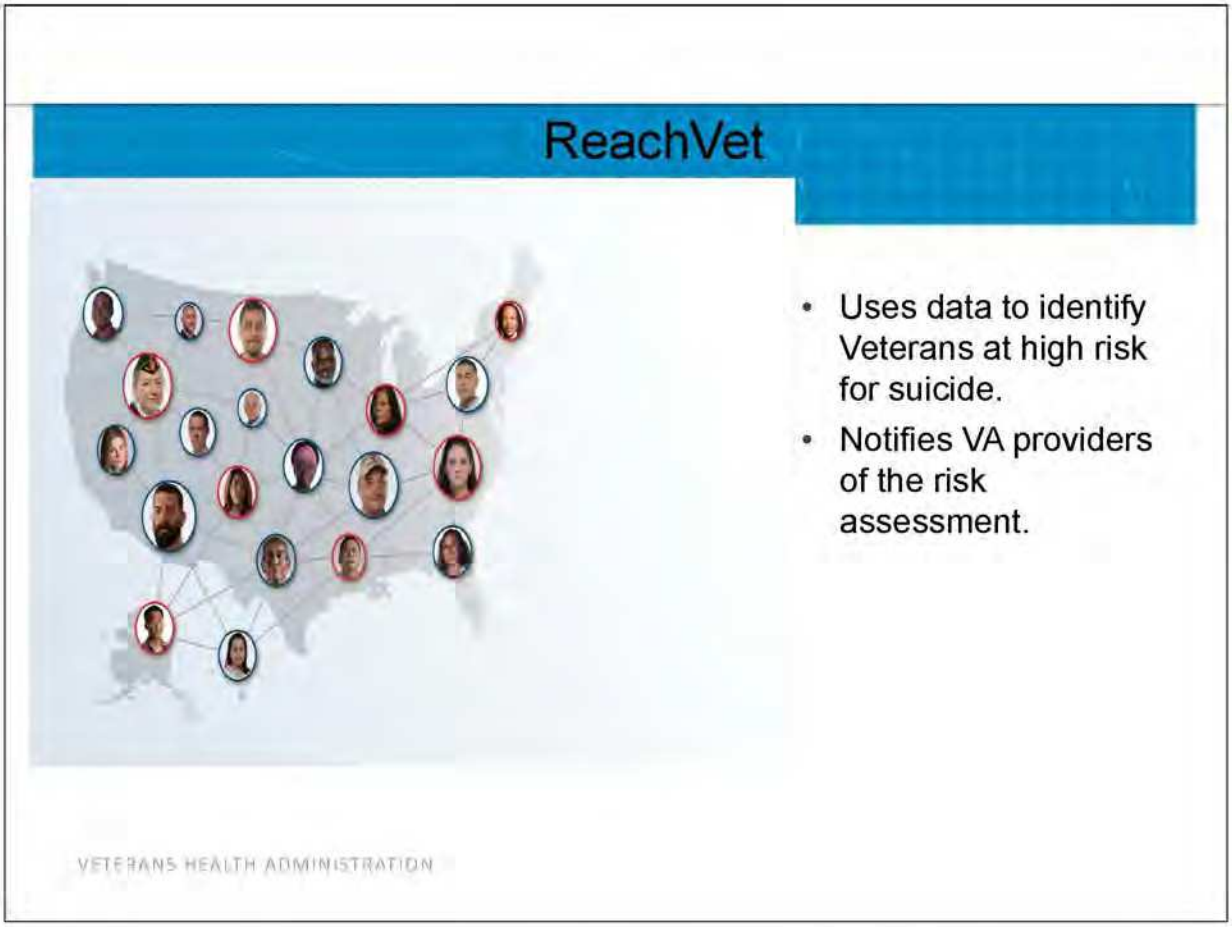

REACH VET uses innovative statistical methods based on VHA data to identify VHA-enrolled Veterans at risk for suicide and other negative outcomes. REACH-VET is a supplement to current clinical strategies of identifying patients at increased risk.

REACH VET identifies Veterans at increased risk and notifies providers of identified Veterans, so providers can reevaluate and enhance the Veteran's care.

REACH VET enhances at risk Veterans' access to care and complements ongoing initiatives to increase access.

REACH VET starts nationwide in September 2016—it will identify thousands of Veterans with complex care needs across the country and ensure that they are receiving the very best evidence-based care.

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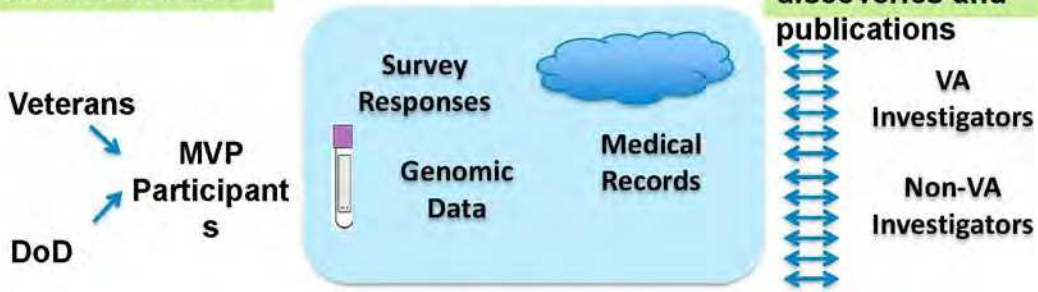
MVP and PMI Summary Objectives:

MVP participation available to all Veterans and DoD

State-of-the-art computational environment

Data access leading to scientific discoveries and publications



- Current enrollment 510,000 veterans
- Enroll at least 1 Million by 2020
- Expand secure computational capacity to serve >1000 simultaneous VA and non-VA researchers by 2020
- Safe/secure, CLIA-compliant biorepository with back-up
- Establish mechanisms to return results responsibly to: Providers, EHR and Participants

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TeleRadiology Program (TRP)

Host Facility: VA Palo Alto Health Care System

Provides remote diagnostic radiology interpretations, with final reports uploaded directly into the patient electronic health record



- Serves **88** VA facilities across all service networks
- Operates from multiple reading centers to ensure 24/7 operation

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Tele-ICU Hubs

VHA Tele-ICU Fact Sheet

VISN 10 Tele-ICU program (Cincinnati)
Connects to other facilities Intensive Care Units



VISN 23 Tele-ICU Program (Minneapolis)
Connects to other Facilities' Intensive Care Units



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VA-19-0799-D-000691
DS_00002360

Telehealth: Clinical Genomics

Hub in Salt Lake City:

- Centralized Genomic Medicine Service started in 2012
- Reaches areas of the country where genetic services are generally unavailable
- Provides direct patient counseling and support to local clinicians
- Care delivered through CBOCs as well as VAMCs to reach Veterans in their communities

Now reaches 80 VAMCs



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VA-19-0799-D-000692
DS_00002361

VA Telehealth Services: Outcomes

Reductions in Utilization FY 2015

- Home Telehealth reduced bed days of care: **58%**
- Home Telehealth reduced hospital admissions: **32%**
- Clinical Video TeleMental health reduced acute psychiatric bed days of care: **35%**

Patient Satisfaction

- Home Telehealth: **89%**
- Store-and-Forward Telehealth: **96%**
- Clinical Video Telehealth: **94%**

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Veteran's Portal: My HealtheVet



My HealtheVet Statistics

Registrants: 3.6 million

Secure Messaging users: 1.7 million

Rx Refill Requests: 81 million

VA Blue Button Downloads: 1.4 million

Change in Appointment Viewers from December 2014 to December 2015: **32%** increase

*Statistics as of March 2016

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Text Messaging



Annie – a mobile messaging system that promotes self-care for Veterans. Annie sends regular, automated text message reminders to Veterans to help them track health information their VA care teams have requested. Annie can also send Veterans reminders and messages from their local VA facility.

Learn More:
https://www.youtube.com/watch?v=zkekNr6DeQY&feature=youtu.be

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VA Mobile Apps



VETERANS HEALTH ADMINISTRATION

Veterans Appointment Request (VAR) – Allows Veterans to directly schedule and cancel selected primary care appointments directly through the app

Veteran Appointment Usability Study Results:

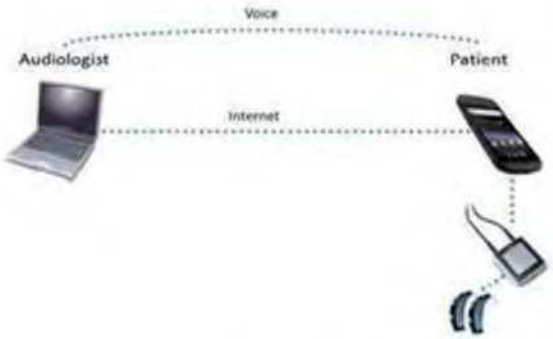
- **76%** satisfied with app
- **95%** believe it has the potential to improve access to care

http://mobile.va.gov/appstore

AMERICAN OVERSIGHT

Mobile Distance Hearing Aid Fitting App

A distance hearing aid fitting application that runs on a smartphone and allows audiologists to perform hearing aid adjustments remotely on hearing aids





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VA-19-0799-D-000697
DS_00002366

Use of Virtual Tools



https://www.youtube.com/watch?v=38pl8hc9aso&feature=youtu.be

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Thank You



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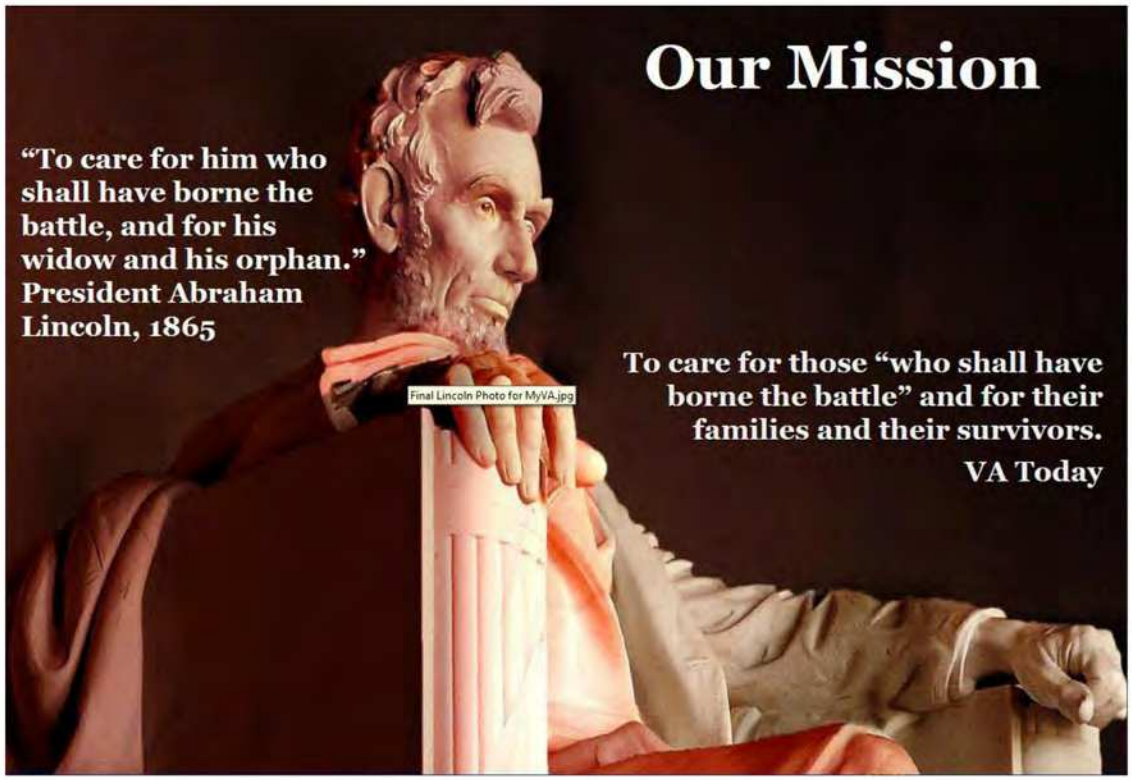
Health Data Palooza

David J. Shulkin, MD
Secretary of Veterans Affairs

April 25, 2017

AMERICAN OVERSIGHT



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Important Contributions to Society



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VA Research



Barcoding of Medications



Nicotine Patches



First Liver Transplant



8 Lasker Awards



Cardiac Pacemaker



3 Nobel Prizes



Artificial Kidney



CT Scanner

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"Out of crisis comes clarity."

Randolph O'Toole

6

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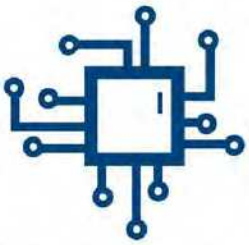
Top 5 Priorities for VA



Greater Choice



Modernize Systems



Focus Resources



Improve Timeliness



Suicide Prevention

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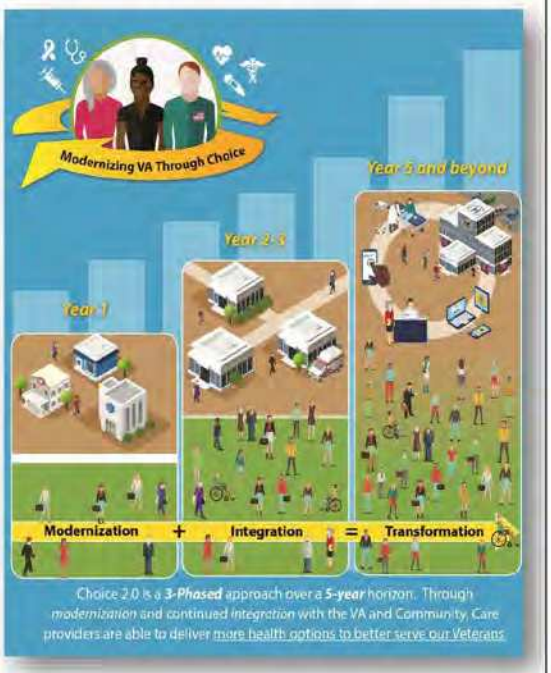
Greater Choice for Veterans

- Redesign the 40/30 Rule
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information



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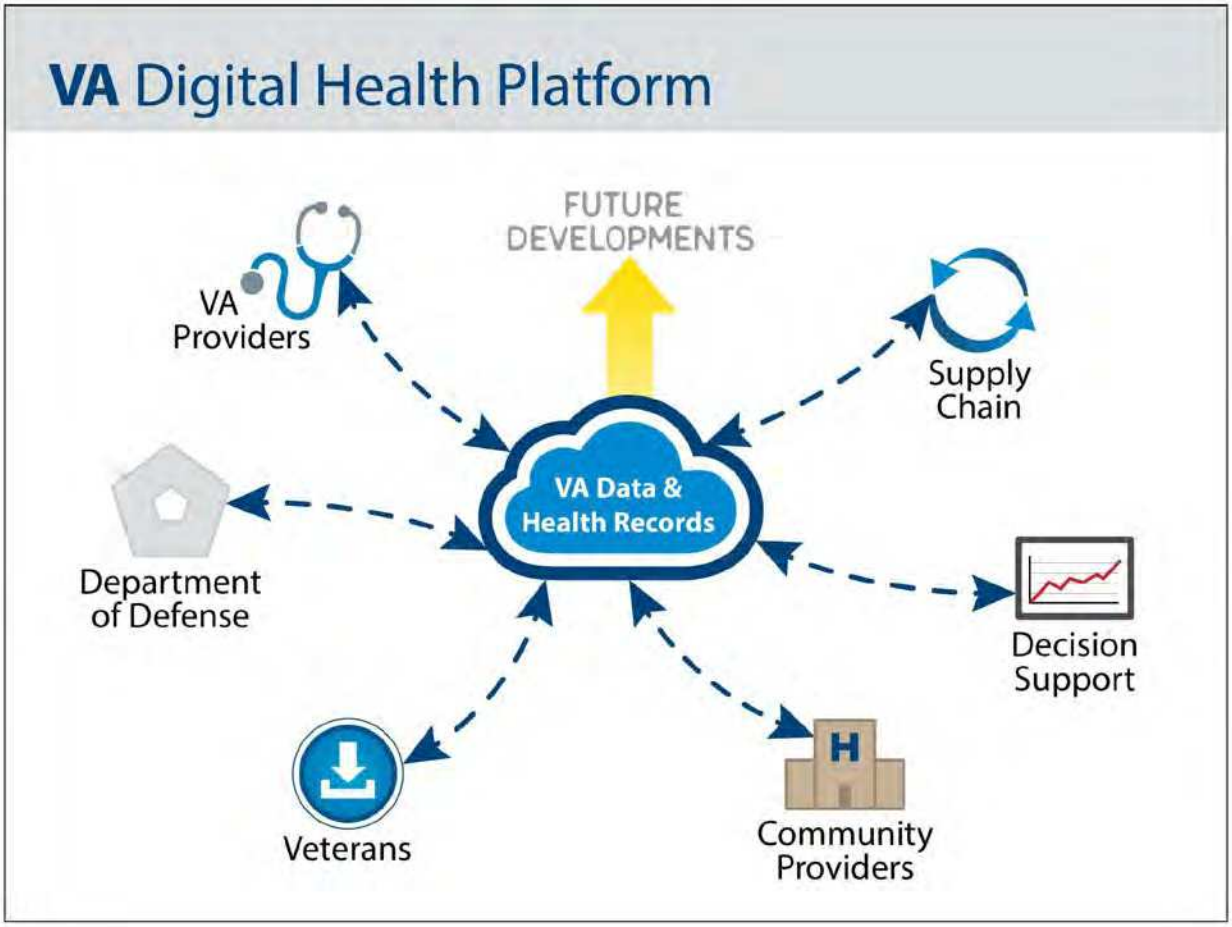

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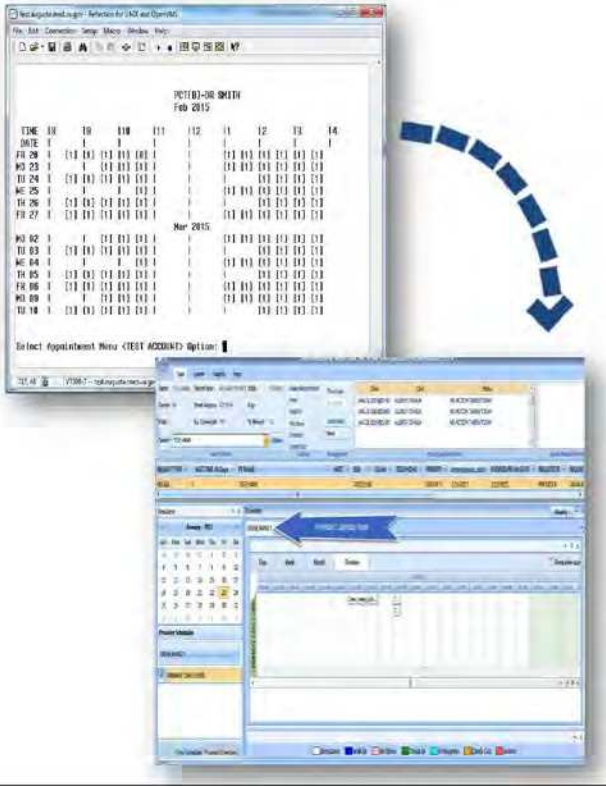
Modernize Our Systems

- EMR interoperability and IT modernization
- Infrastructure improvements and streamlining services



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Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

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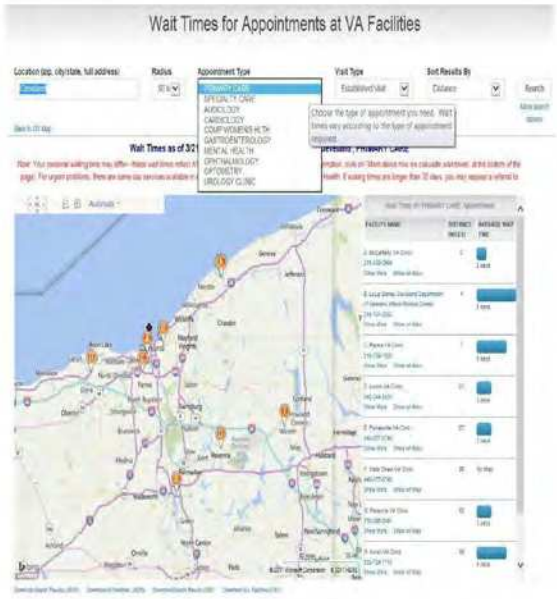
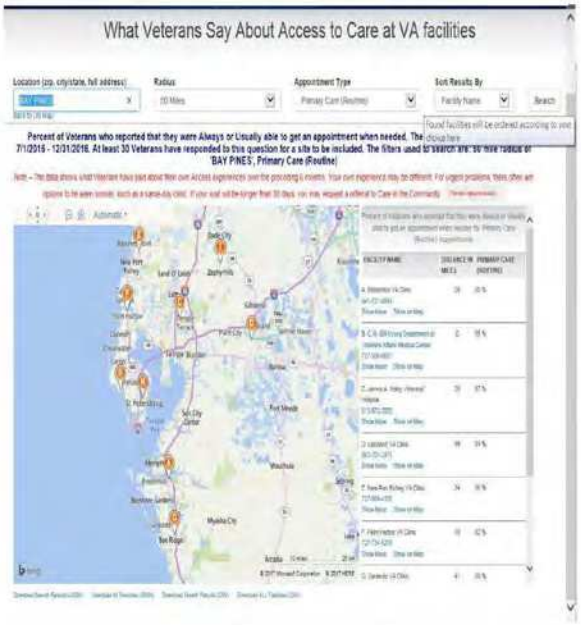
Wait times at local facilities



What Veterans are saying about access



1
2

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Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

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Delivering Care Where We Don't Have Facilities





14

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VA Telehealth Services

2.14 million episodes to 677,000 Veterans (12%)



Home Telehealth
156,000 Veterans



Video Telehealth
282,000 Veterans



Store-and-Forward Telehealth

298,000 Veterans

45% of our Telehealth services are for rural Veterans

336,000 TeleMental health visits

15

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That's My Ear!

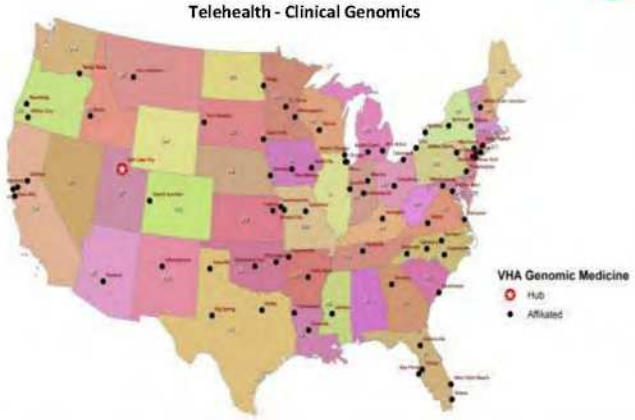


AMERICAN OVERSIGHT

Tele-ICU Hubs



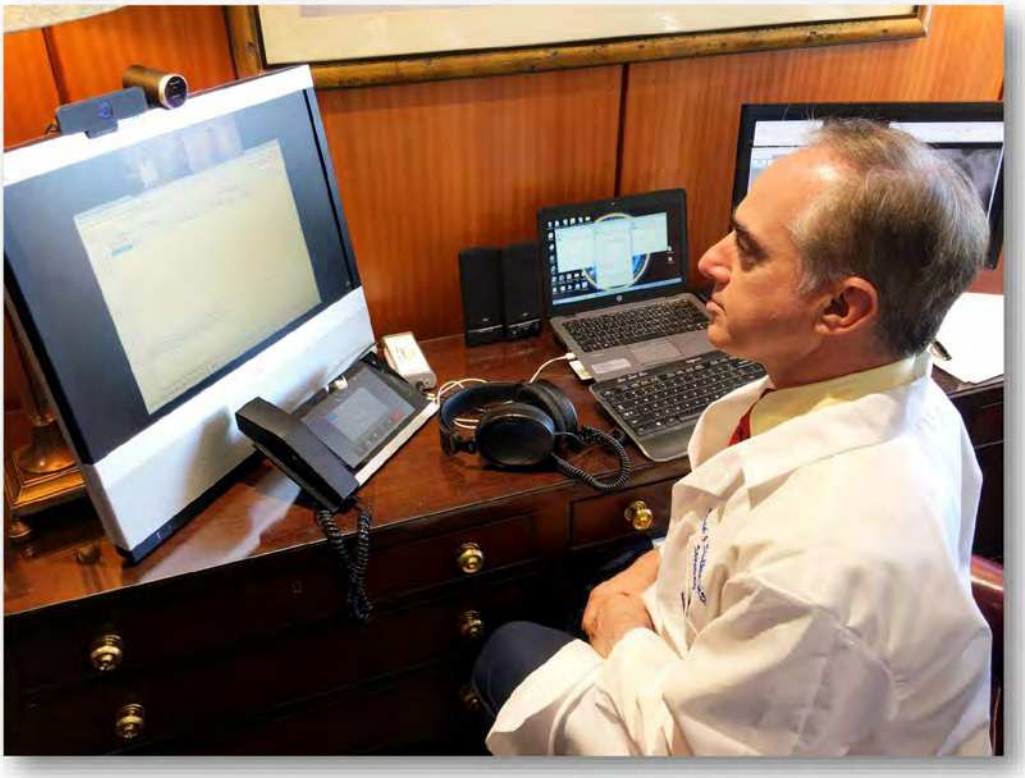
Telehealth - Clinical Genomics



TeleRadiology Program



AMERICAN OVERSIGHT



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Taking the Lead in Healthcare Big Data

- Big Data Announcement Slide

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Predictive Analytics



- **Oncology**
- **PTSD**
- **TBI**
- **Suicide**

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Genomics Data: 520,000 Enrolled



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VA Mobile Apps



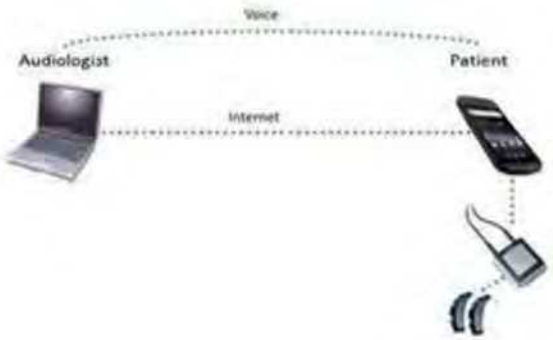


- **Veteran Appointment Request (VAR)** – Allows Veterans to directly schedule and cancel selected primary care appointments directly through the app
- **Veteran Appointment Usability Study:**
  - ❑ **76%** satisfied with the app
  - ❑ **95%** feel that it has the potential to improve access to care
  - ❑ http://mobile.va.gov/appstore

AMERICAN OVERSIGHT

Mobile Distance Hearing Aid Fitting App

A distance hearing aid fitting application that runs on a smartphone and allows audiologists to perform hearing aid adjustments remotely on hearing aids





AMERICAN OVERSIGHT

Veteran's Portal - MyHealtheVet



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*Statistics as of March 2016

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Improve Timeliness of Services

- Access to care and wait times
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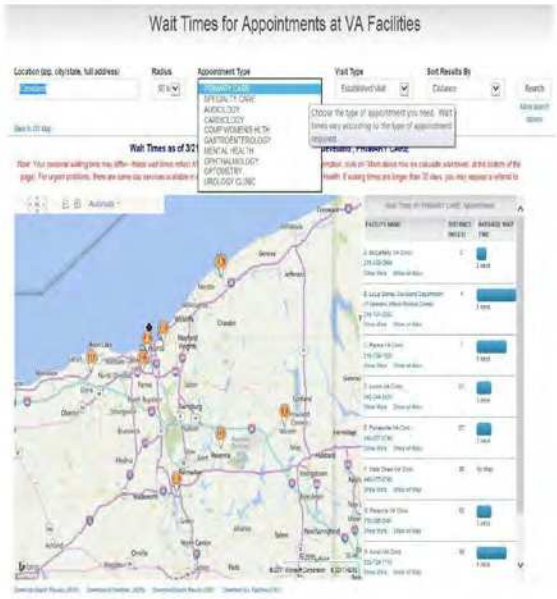
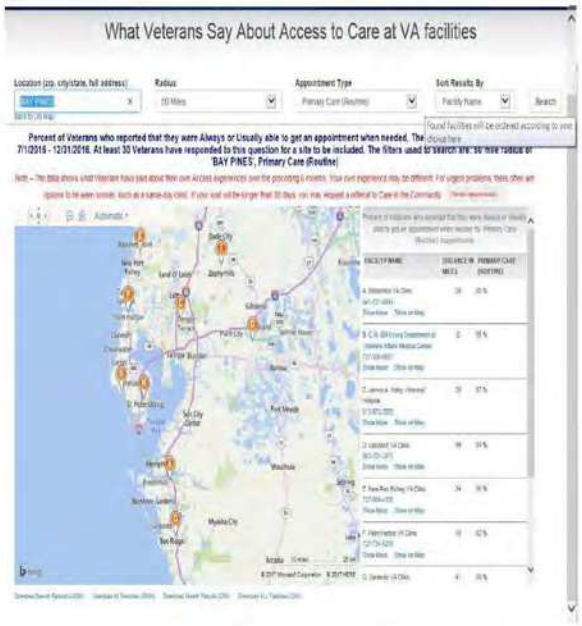
Wait times at local facilities



What Veterans are saying about access



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Suicide Prevention

- Getting to ZERO



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Predictive Analytics: REACH VET



- Rolled out nationally
- Uses data to identify Veterans at high risk for suicide
- Notifies VA providers of the risk assessment

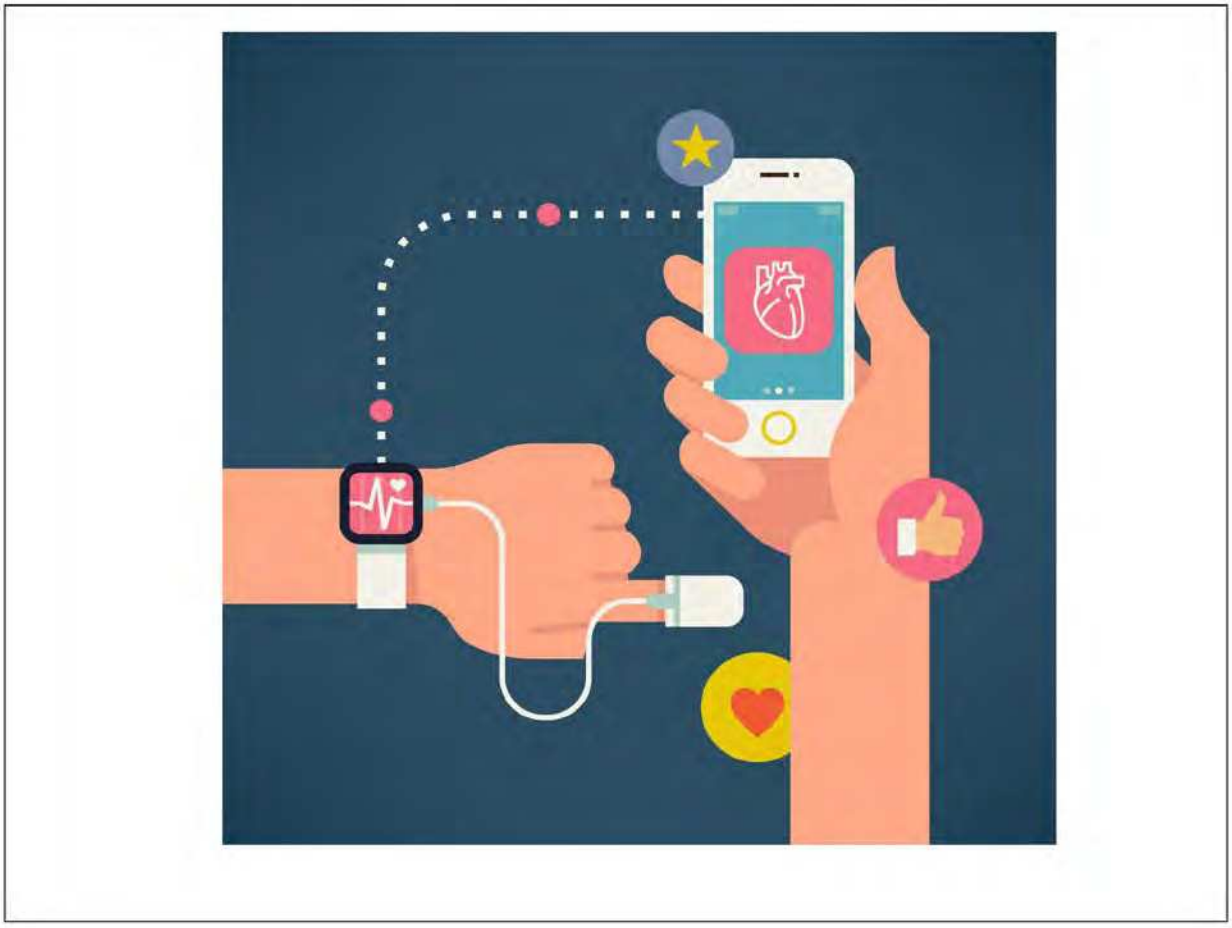
AMERICAN OVERSIGHT

Center for Compassionate Innovation

To enhance Veterans health and well-being by offering safe and ethical therapies after traditional treatments have not been successful



AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Veterans Day Parade

https://www.youtube.com/watch?v=38pl8hc9aso&feature=youtu.be

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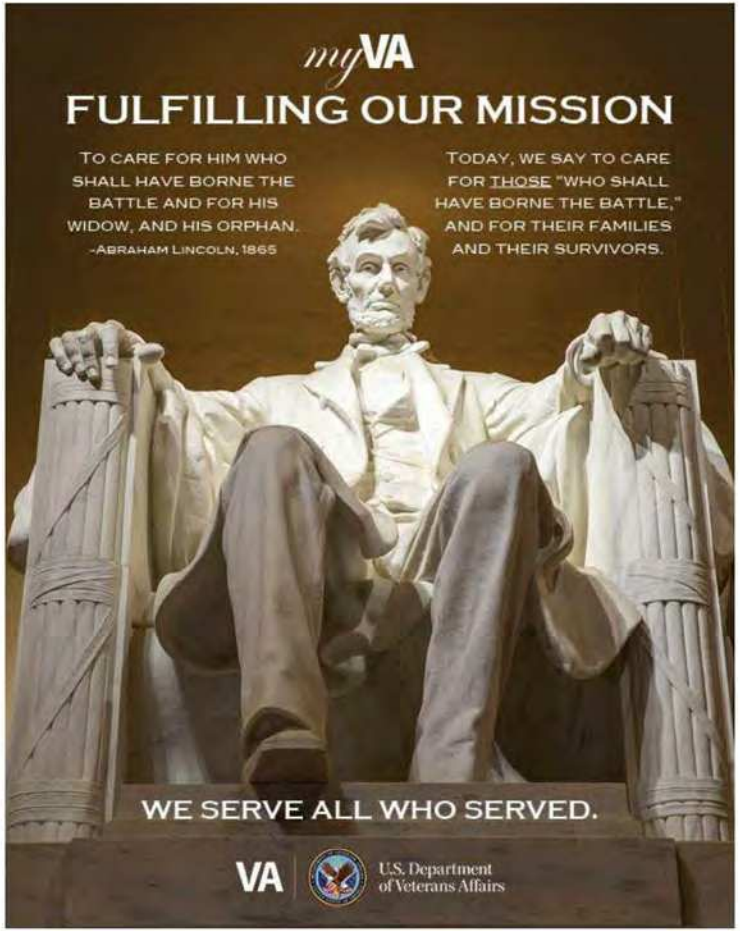
VA Modernization

Health Datapalooza

David J. Shulkin, MD
Secretary of Veterans Affairs

April 28, 2017

AMERICAN OVERSIGHT
VA-19-0799-D-000733
DS_00002402


myVA
FULFILLING OUR MISSION
TO CARE FOR HIM WHO SHALL HAVE BORNE THE BATTLE AND FOR HIS WIDOW, AND HIS ORPHAN.
-ABRAHAM LINCOLN, 1865
TODAY, WE SAY TO CARE FOR THOSE "WHO SHALL HAVE BORNE THE BATTLE," AND FOR THEIR FAMILIES AND THEIR SURVIVORS.
WE SERVE ALL WHO SERVED.
VA
U.S. Department of Veterans Affairs

Honoring Those Who Served

'Final Salute' honors Holocaust survivor, Veteran



VA Research



Barcoding of Medications



Nicotine Patches



SUCCESS REPORTED IN LIVER TRANSPLANT

DENVER, May 11 (AP)— The first successful surgical transplant of a human liver was disclosed by surgeons here today.

Two teams of doctors accomplished the feat in a six-hour operation at Veterans Administration Hospital last Sunday.

The patient, William Grigsby, 47 years old, of Denver, is said by surgeons to be responding well, showing all signs of recovery after the first critical week, and that the operation is apparently a success.

Mr. Grigsby, a janitor at the Denver County jail, was dying of a malignant tumor when the surgery was proposed to him, a hospital official said. The healthy liver was taken from another V.A. hospital patient minutes after he died of a brain tumor.

Only once before has a liver transplant been known to have been attempted between humans. That was at the same hospital here, two months ago. The patient died.

Spokesmen said the transplant, if successful, would open up a new area of treatment to previously incurable diseases amenable to this type of surgery. But they emphasize the technique is meticulous and complex, with many perils.

The New York Times

First Liver Transplant



8 Lasker Awards



Cardiac Pacemaker



3 Nobel Prizes



Artificial Kidney



CT Scanner

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VA-19-0799-D-000736

DS_00002405

Current Research



- Almost 10,000 peer-reviewed studies published last year:
  - 1,800 on Access
  - 577 on PTSD
  - 386 on Suicide
  - 230 on TBI
- $680 million invested in research

Important Contributions to Society



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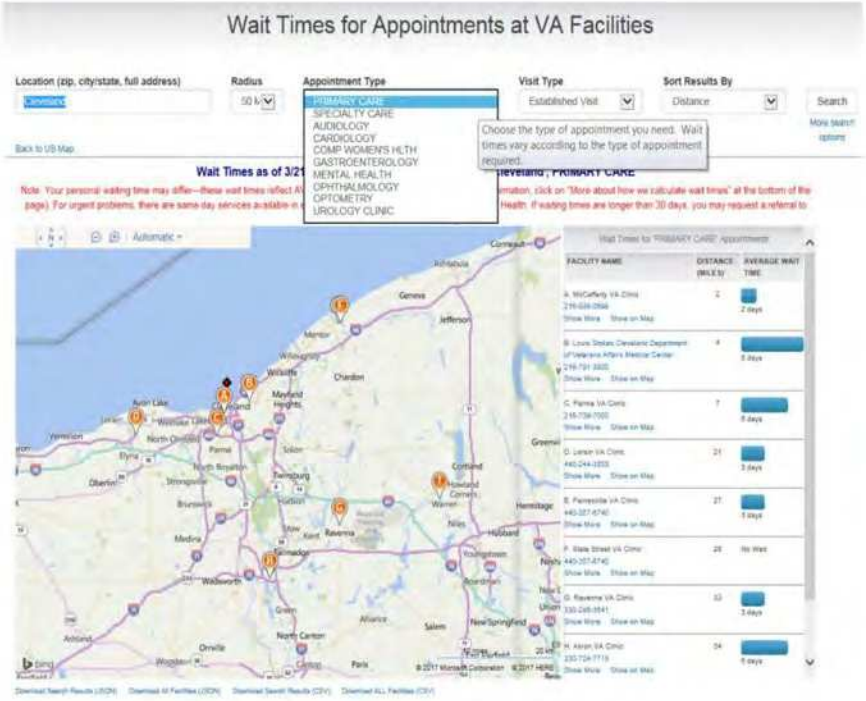
VA-19-0799-D-000738
DS_00002407

“Out of crisis comes clarity.”

Randolph O’Toole

VA-19-0799-D-000739
DS_00002408

Wait times at local facilities



What Veterans are saying about access



VA-19-0799-D-000740
DS_00002409

Center for Compassionate Innovation

To enhance Veterans health and well-being by offering safe and ethical therapies after traditional treatments have not been successful



AMERICAN OVERSIGHT

VA-19-0799-D-00074

DS_00002410

Suicide Prevention Strategies



Expand the VA Suicide Prevention Office

Reach Veterans and their families

Develop innovative prevention strategies

Change the conversation around suicide

Build community engagement

AMERICAN OVERSIGHT

VA-19-0799-D-000742

DS_00002411

Delivering Care Where We Don't Have Facilities





VA Telehealth Services

2.14 million episodes to 677,000 Veterans (12%)



Home Telehealth
156,000 Veterans



Video Telehealth
282,000 Veterans



Store-and-Forward Telehealth
298,000 Veterans

45% of our Telehealth services are for rural Veterans

336,000 TeleMental health visits

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VA-19-0799-D-000744

That's My Ear!



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VA-19-0799-D-000745

DS_00002414

Tele-ICU Hubs

VHA Tele-ICU Fact Sheet

VISN 10 Tele-ICU program (Cincinnati)
Connects to other facilities Intensive Care Units



VISN 23 Tele-ICU Program (Minneapolis)
Connects to other Facilities' Intensive Care Units



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VA-19-0799-D-000746

DS_00002415

TeleRadiology Program (TRP)

Host Facility: VA Palo Alto Health Care System

Provides remote diagnostic radiology interpretations, with final reports uploaded directly into the patient electronic health record



- Serves **88** VA facilities across all networks
- Operates from multiple reading centers to ensure 24/7 operation

AMERICAN OVERSIGHT

VA-19-0799-D-000747

DS_00002416

Telehealth - Clinical Genomics

Hub in Salt Lake City:

- ❑ Centralized Genomic Medicine and Counseling service started in 2012
- ❑ Reaches areas of the country where genetic services are generally unavailable
- ❑ Provides direct patient counseling and support to local clinicians
- ❑ Care delivered through CBOCs as well as VAMCs to reach Veterans in their communities



Now reaches 80 VAMCs

VA Telehealth Services: Outcomes

Reductions in Utilization FY 2015

- ❑ Reduced bed days of care - **58%**
- ❑ Reduced hospital admissions - **32%**
- ❑ Reduced acute psychiatric bed days of care - **35%**

Patient Satisfaction

- ❑ Home Telehealth - **89%**
- ❑ Store-and-Forward Telehealth - **96%**
- ❑ Clinical Video Telehealth - **94%**

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VA-19-0799-D-000749
DS_00002418



AMERICAN OVERSIGHT

VA-19-0799-D-000750

Predictive Analytics



- Oncology
- PTSD
- TBI
- Suicide

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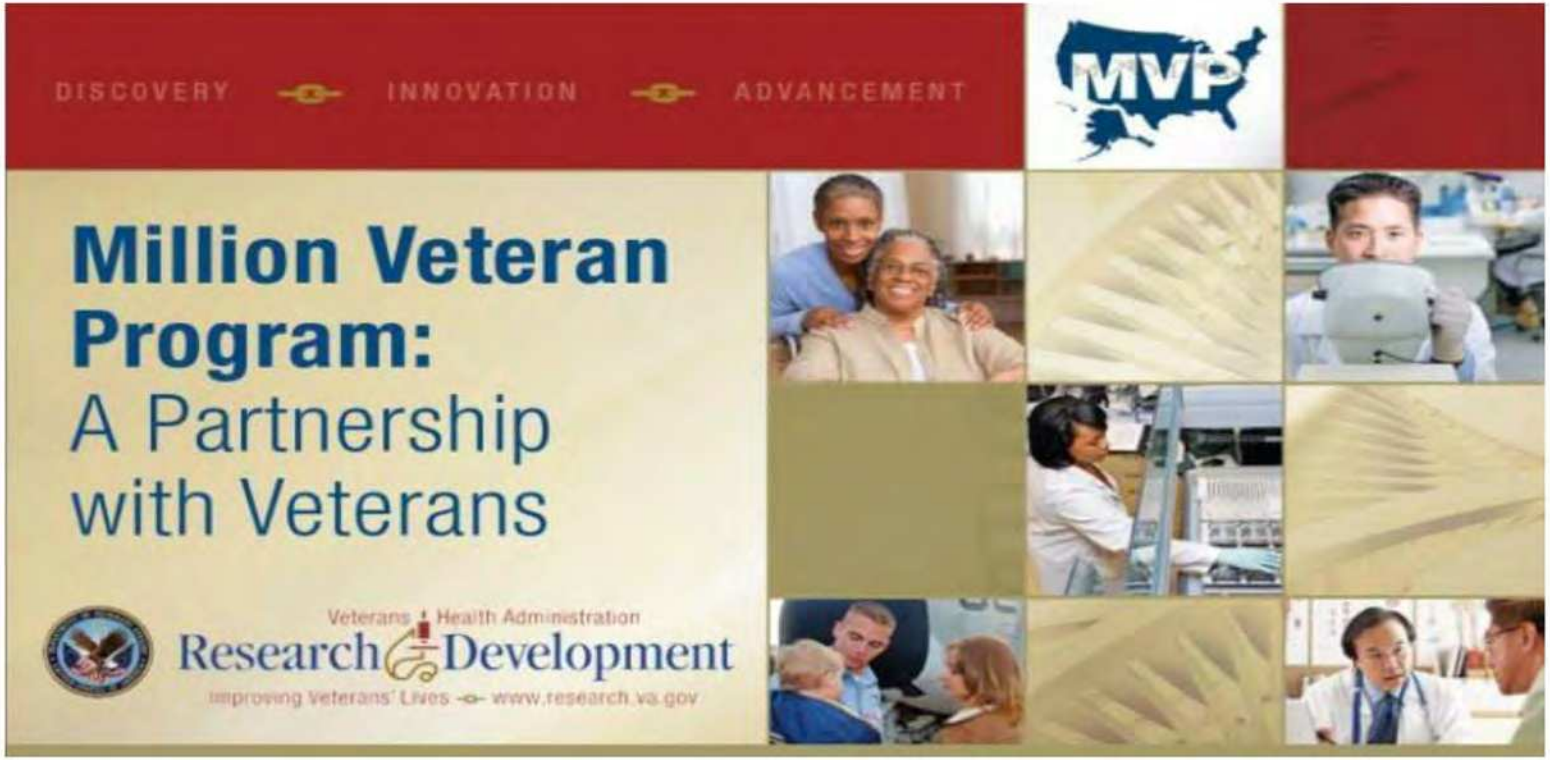
VA-19-0799-D-00075

Genomics Data: 520,000 Enrolled



AMERICAN OVERSIGHT

VA-19-0799-D-000752

VA Mobile Apps



http://mobile.va.gov/appstore



Veteran Appointment Request (VAR) – Allows Veterans to directly schedule and cancel selected primary care appointments directly through the app

Veteran Appointment Usability Study:

- ❑ **76%** satisfied with the app
- ❑ **95%** feel that it has the potential to improve access to care

Veteran's Portal - MyHealtheVet



My HealtheVet Statistics

- ❑ Registrants: 3.6 million
- ❑ Secure Messaging users: 1.7 million
- ❑ Rx Refill Requests: 81 million
- ❑ VA Blue Button Downloads: 1.4 million
- ❑ Change in Appointment Viewers from December 2014 to December 2015: 32% Increase

*Statistics as of March 2016

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VA-19-0799-D-000754

DS_00002423

Mobile Distance Hearing Aid Fitting App

A distance hearing aid fitting application that runs on a smartphone and allows audiologists to perform hearing aid adjustments remotely on hearing aids





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VA-19-0799-D-000755
DS_00002424

MVP and PMI Summary Objectives

MVP participation available to all Veterans and DoD

Veterans
DoD
→ MVP Participants

State-of-the-art computational environment



Data access leading to scientific discoveries and publications



VA Investigators

Non-VA Investigators

- Current enrollment **520,000** Veterans
- Enroll at least **1 Million** by 2020
- Expand computational capacity to serve more than **1,000** simultaneous VA and non-VA researchers by 2020
- Safe/secure, CLIA-compliant biorepository with back-up
- Establish mechanisms to return results responsibly to providers, EHR, and participants

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VA-19-0799-D-000756

Predictive Analytics: REACH VET



- Rolled out nationally
- Uses data to identify Veterans at high risk for suicide
- Notifies VA providers of the risk assessment

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VA-19-0799-D-000757

DS_00002426

MVP Enrollment Sites



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VA-19-0799-D-000758
DS_00002427

VA Need Partners and Technology



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VA-19-0799-D-000759

DS_00002428

Thank You



VA-19-0799-D-000760
DS_00002429

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/26/2017 2:04:36 PM
To: [redacted] [redacted]mayo.edu]
Subject: Re: Details | Thursday

I totally understand [redacted]

Sent from my iPhone

> On Apr 26, 2017, at 9:14 AM, [redacted] <[redacted]mayo.edu> wrote:
>
> Hi David - thank you for the kind offer of access to the Thursday, 4:30 p.m. event. Unfortunately, I have commitments back here at Mayo/Rochester that require that I depart DC late morning, Thursday.
>
> Hope your meeting w/ your large group of leaders continues to go well -- thank you for your continued strong leadership of the VA and for our nation's veterans.
>
> [redacted]
>
> -----Original Message-----
> From: David Shulkin [mailto:drshulkin@aol.com]
> Sent: Tuesday, April 25, 2017 9:20 PM
> To: IP
> Cc: [redacted]
> Subject: Re: Details | Thursday
>
> Sorry just getting in and now just seeing your message
>
> I have my top 500 leaders in Virginia today and this was my afternoon to tell them where we need to change- I've been out of cell range.
>
> I'll get [redacted] on the list for the event. 430 pm on Thursday
>
> We have to be in the building by 2 as per secret service
>
> David
>
>
> Sent from my iPad
>
>> On Apr 25, 2017, at 3:51 PM, IP <[redacted]renchangel59.com> wrote:
>>
>>
>
>

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted] [redacted]mayo.edu]
Sent: 4/26/2017 1:14:08 PM
To: David Shulkin [drshulkin@aol.com]
CC: IP [redacted]frenchangel59.com]
Subject: Details | Thursday

Hi David - thank you for the kind offer of access to the Thursday, 4:30 p.m. event. Unfortunately, I have commitments back here at Mayo/Rochester that require that I depart DC late morning, Thursday.

Hope your meeting w/ your large group of leaders continues to go well -- thank you for your continued strong leadership of the VA and for our nation's veterans.

[redacted]

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From: David Shulkin [mailto:drshulkin@aol.com]
Sent: Tuesday, April 25, 2017 9:20 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Details | Thursday

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We have to be in the building by 2 as per secret service

David

Sent from my iPad

> On Apr 25, 2017, at 3:51 PM, IP <[redacted]frenchangel59.com> wrote:
>
>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/26/2017 2:20:28 AM
To: IP [(b) (6)frenchangel59.com]
CC: (b) (6) (b) (6) [(b) (6) mayo.edu]
Subject: Re: Details | Thursday

Sorry just getting in and now just seeing your message

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I'll get (b) (6) on the list for the event. 430 pm on Thursday

We have to be in the building by 2 as per secret service

David

Sent from my iPad

> On Apr 25, 2017, at 3:51 PM, IP <(b) (6)frenchangel59.com> wrote:
>
>

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/25/2017 7:51:31 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: Details | Thursday

Please give me a call. Thank you

From: (b) (6) [mailto(b) (6)mayo.edu]
Sent: Tuesday, April 25, 2017 3:32 PM
To: Marisol Garcia ((b) (6)frenchangel59.com)
Cc: IP ((b) (6)frenchangel59.com); Bruce Moskowitz; Marc Sherman ((b) (6)gmail.com)
Subject: Details | Thursday

Hi Marisol – can you send what you have in terms of details for Thursday – location/timeline of meetings – if possible before 4:45 EDT.

Thanks,

(b) (6)
Chair |Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905
cell: 507.269.(b) (6) |office: 507.284.(b) (6)
e-mail: (b) (6)mayo.edu

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/14/2017 2:32:35 AM
To: Poonam Alaigh [(b) (6) hotmail.com]

Missals comments are overboard- very dissapointing he is playing to the press

https://www.washingtonpost.com/local/dc-politics/highest-levels-of-chaos-impair-dc-veterans-hospital-inspector-general-finds/2017/04/13/777bc786-203d-11e7-ad74-3a742a6e93a7_story.html?utm_term=.298ade90d0f2

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/20/2017 12:31:14 AM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re:

This would be interesting

You know everyone!

Sent from my iPhone

On May 19, 2017, at 6:27 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> After you were off phone my next call was to (b) (6) chairman of Bristol there are enough managers in the pharmaceutical industry he believes to assist filling management positions. We think between this and the business schools we can do it. Mayo has an internship with Baylor. If you can leave Texas for Minnesota that is something!!
>
> Sent from my iPhone
>
> On May 19, 2017, at 6:09 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > From morning joe show today- talking up the president
> >
> > http://www.newsmax.com/t/newsmax/article/791121?section=Politics&keywords=david-shulkin-veterans-affairs-leaders&year=2017&month=05&date=19&id=791121&aliaspath=%2FManage%2FArticles%2FTemplate-Main&oref=www.google.com
> >
> > Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 5/19/2017 10:27:17 PM
To: David shulkin [Drshulkin@aol.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re:

After you were off phone my next call was to (b) (6) chairman of Bristol there are enough managers in the pharmaceutical industry he believes to assist filling management positions. We think between this and the business schools we can do it. Mayo has an internship with Baylor. If you can leave Texas for Minnesota that is something!!

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> From morning joe show today- talking up the president
>
> http://www.newsmax.com/t/newsmax/article/791121?section=Politics&keywords=david-shulkin-veterans-affairs-leaders&year=2017&month=05&date=19&id=791121&aliaspath=%2FManage%2FArticles%2FTemplate-Main&oref=www.google.com
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/19/2017 10:09:40 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]

From morning joe show today- talking up the president

http://www.newsmax.com/t/newsmax/article/791121?section=Politics&keywords=david-shulkin-veterans-affairs-leaders&year=2017&month=05&date=19&id=791121&aliaspath=%2FManage%2FArticles%2FTemplate-Main&oref=www.google.com

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/14/2017 7:05:12 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Tracking inventory

I look forward to meeting him- thanks

Sent from my iPhone

On Apr 14, 2017, at 9:39 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> One of the CIO's your meeting April 17 is (b) (6) mentioned below.
> The actual application that I am most interested in applying for a device registry is to insure appropriate procurement, utilization and tracking of devices throughout the VA system. This is any device internal and external. I have enough data to show it (not in an email) what occurred the past few days is not an anomaly. This was also in the full report that (b) (6) participated in not the summary.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> Begin forwarded message:
>
> > **From:** Aaron Moskowitz <(b) (6) brefnet.org>
> > **Date:** April 13, 2017 at 3:54:30 PM EDT
> > **To:** "Bruce Moskowitz M.D." <(b) (6) mac.com>
> > **Subject: VA call follow up**
> >
> > I think the group has a good framework for the clinical applications. I was in Baltimore this morning with (b) (6) and discussed the actual problem of tracking devices throughout the medical system, not just in patients. Apparently Hopkins has been so successful at this they have a company, fully owned by Johns Hopkins, that sets up inventory management at hospitals. We brainstormed a bit on other methods to link implant information to patient records, a "smart" inventory system could help this process.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/14/2017 1:39:33 PM
To: Poonam Alaigh [(b) (6) hotmail.com]; David Shulkin [drshulkin@aol.com]
Subject: Tracking inventory

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The actual application that I am most interested in applying for a device registry is to insure appropriate procurement, utilization and tracking of devices throughout the VA system. This is any device internal and external. I have enough data to show it (not in an email) what occurred the past few days is not an anomaly. This was also in the full report that (b) (6) participated in not the summary.

Sent from my iPad
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/15/2017 2:11:49 AM
To: Charlie Wiggins [(b) (6) remedyventures.com]
Subject: Re: Home - Malone Center for Engineering in Healthcare

Ok great Charlie

Sent from my iPhone

On Apr 14, 2017, at 9:30 PM, Charlie Wiggins <(b) (6) remedyventures.com> wrote:

> Secretary Shulkin,
>
> Often times while building a new initiative I find it helpful to free-form brainstorm to capture ideas while cultivating vision. I've found using the open source software mindnode to be one effective way to share those ideas amongst a team, remotely.
>
> Attached and pasted below is an initial draft of a semantic tree of sorts that captures notable accomplishments from the VACI to date and provides some additional avenues to consider as we move forward. It is by no means a comprehensive document, but if you don't hate the layout it can be a way we begin to structure thought/effort as we begin working together.
>
> Looking forward to taking the next steps and walking you through some of these concepts during our next conversation.
>
> Have a great weekend,
>
> Charlie
>
> <image.png>
>
> On Wed, Apr 12, 2017 at 12:47 PM, David shulkin <Drshulkin@aol.com> wrote:
> Ok great
>
> Sent from my iPhone
>
> On Apr 12, 2017, at 3:37 PM, Charlie Wiggins <(b) (6) remedyventures.com> wrote:
>
> > The Malone center is onto some interesting work - the Galen System, microsurgical robotics platform and the Kata Studio - are two that stick out as being beneficial for patients and clinicians within the VA.
> >
> > I have only spoke with the White House Liaison to the VA, (b) (6) yesterday and submitted all the necessary documentation here: https://apply.ptt.gov/
> > (b) (6) also has a copy of the attached Bio, so I suspect he will be moving the process along.
> >
> > Please let me know what else I can do to be helpful to your internal process.

AMERICAN OVERSIGHT

Thanks for sharing,

Charlie

On Wed, Apr 12, 2017 at 1:48 PM, David shulkin <Drshulkin@aol.com> wrote:

More good stuff

Has anyone cobtacted you from VA
Sent from my iPhone

Begin forwarded message:

Date: April 12, 2017 at 1:34:43 PM EDT
To: drshulkin@aol.com, Poonam Alaigh <(b) (6) hotmail.com>
Subject: Home - Malone Center for Engineering in Healthcare

Dr. (b) (6) is Mandela Bellmore Professor of Computer science and I will have an initial call to see if we can get their innovative technology center to provide their expertise as a service to their Country and the VA.
https://malonecenter.jhu.edu/

Sent from my iPad
Bruce Moskowitz M.D.

--
Charles Wiggins
203.856.(b)
<SKC_SES Bio Sheet PDF.pdf>

--
Charles Wiggins
203.856.(b)
<Veterans Administration Innovation Center.mindnode.zip>

AMERICAN OVERSIGHT

Message

From: Charlie Wiggins [(b) (6) remedyventures.com]
Sent: 4/15/2017 1:30:21 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Home - Malone Center for Engineering in Healthcare
Attachments: Veterans Administration Innovation Center.mindnode.zip

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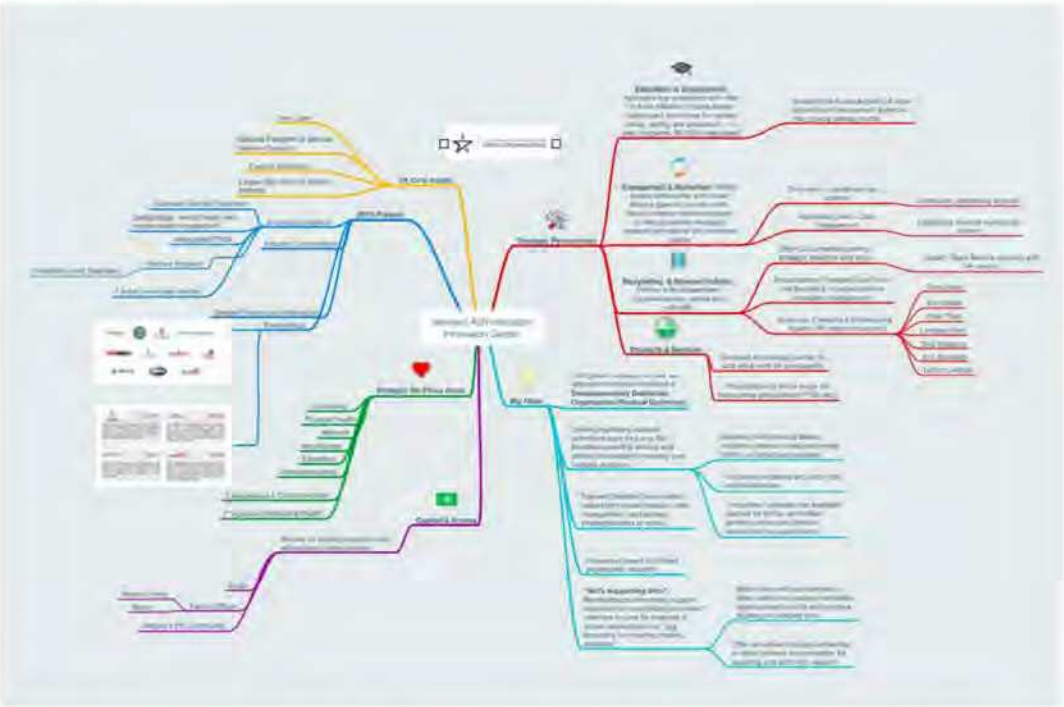

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AMERICAN OVERSIGHT

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To: drshulkin@aol.com, Poonam Alaigh <(b) (6) hotmail.com>
Subject: Home - Malone Center for Engineering in Healthcare

Dr. (b) (6) is Mandela Bellmore Professor of Computer science and I will have an initial call to see if we can get their innovative technology center to provide their expertise as a service to their Country and the VA.
https://malonecenter.jhu.edu/

Sent from my iPad
Bruce Moskowitz M.D.

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Charles Wiggins
203.856(b)
<SKC_SES Bio Sheet PDF.pdf>

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Charles Wiggins
203.856.(b)

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!^$%&_(`~ƒ„ˆQŽ[layoutStyle_decreasingStrokeWidth¦aéCTûÙ !#b$%&(cQQ]isLeftAligned¤d'òÏÙ !#e$%&(fz{€Q‰Q']isLeftAligned¡gØ !h$%&()jkQpuQy]isLeftAligned _{-666.0234375, -695.109375}Ò,lmXpathTypeÓ/012n_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?qtÓ/01rs#@_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHw_ô Shorter time to productivity & more rational post deployment schedule than typical college model _$337EB34E-75D6-4C2D-A3B4-C4F15650939D_*{-1080.8007812499986, -793.44815340910895}Ò,|}XpathTypeÓ/01~#@_({0.863000, 0.133000, 0.157000, 1.000000}Õ8,67ƒQ…†‡Vtinted[clipArtNameX{60, 60}_MNClipArt_Color_Education.pdf_(DA648317-8C34-4D1B-8566-D57F1AAD8506.pdfÓ=>?ŠŒÓ/01r‹_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_' Education to Employment: Approach key employers with offer to have Mission U types design customized curriculum for veteran study, testing and placement. 1-2 year programs, 80-90% web-based _$725656AD-843B-4178-B11F-A3B48EA87414Ù !#"$%&("ÞßãQéíQñ]isLeftAligned¢•°Ø !-$%&(-«¬Q±µQ¹]isLeftAligned¡˜Ø !™$%&()›œQ¢¦Qª]isLeftAligned _{-366.1328125, -450.984375}Ò,žXpathTypeÓ/01Ÿ #@_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?£¥Ó/01r¤_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH¨_¬ Community enhancing apparel _$040815B1-5415-4BF9-BDAA-0FE23693CE15_*{-684.99822443181483, -478.93394886367889}Ò,-®XpathTypeÓ/012¯_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?²´Ó/01r³_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH·_» Entry-level = profile set up + 3 actions _$BDFFF4E2-6413-4781-B1AE-C11091B152B4Ø
!»$%&(¼ÏÐQÕÙQÝ]isLeftAligned¡½Ø !¾$%&()ÀÁQÆÊQÎ]isLeftAligned _{-364.359375, -399.015625}Ò,ÂÃXpathTypeÓ/01ŸÄ_({0.863000, 0.133000, 0.157000,

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1.000000}Ó=>?ÇÉÓ/01rÈ_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÌ_´ Health box Remote monitoring system _$6176D5A2-7AAE-458D-B90B-1873B8DD7BAE_{-653.6640625, -412.1328125}Ò,ÑÒXpathTypeÓ/012Ó_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?ÖØÓ/01r×_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÛ_² Advanced Level = Daily Engagement _$E7472FA6-3CE3-49B4-91EB-71F0251C5178_*{-1083.7141335227252, -553.77201704549407}Ò,àáXpathTypeÓ/01~â_({0.863000, 0.133000, 0.157000, 1.000000}Õ8,67äQæ†çX{60, 60}_MNClipArt_Color_Repeat.pdf_(ADC39532-6A02-46E5-A193-BC11ABAF76B2.pdfÓ=>?êìÓ/01rë_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHï_7 Engagement & Activation: Initially, broker relationship with Under Armour types to provide multi-tiered incentive rewards program for Vets to provide feedback, research and data to VA Innovation Center _$9D501593-2686-403A-BD36-879C9B992057Ù !#ó$%&(ô»¼ÀQÆÊQÎ]isLeftAligned£õ+Ø !ö$%&(÷QQ]isLeftAligned¡øØ !ù$%&()ûüQQ]isLeftAligned _*{-349.89842224121094, -311.82084655761719}Ò,ýþXpathTypeÓ/01Ÿÿ_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?Ó/01r_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_¾ Idea#1: Track Service Journey with VA overlay _$3EF7B82C-F4E4-49AF-A4A2-9818F16CE389_{-703.28125, -332.4453125}Ò,XpathTypeÓ/012_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?Ó/01r_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_É Micro Documentary setting strategic direction and focus _$63A235D7-6B81-4EB7-9096-7C2A8DCD4BBCØ !$%&()Q"&Q*]isLeftAligned _{-712.421875, -257.6953125}Ò,XpathTypeÓ/012 _({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?#%Ó/01r$_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH(oé Broadcasters Fireside Chats with the Secretary on organizational innovation management _$5B5EEEF0-A6BB-426A-B7B3-7E8CCE0C4303Ø !,$%&(-¬-Q²¶Q°]isLeftAligned§.@Rdvˆšø !/$%&()12Q7;Q?]isLeftAligned _){-337.0134449005127, -242.26948928833008}Ò,34XpathTypeÓ/01Ÿ5_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?8:Ó/01r9_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH=_š Tom Brady _$F8F7D628-DF70-48D6-BE7B-CF07615345FEØ !A$%&()CDQIMQQ]isLeftAligned _*{-338.89516129034746, -201.27906586021516}Ò,EFXpathTypeÓ/01ŸG_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?JLÓ/01rK_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHO_š<p style='color: rgba(52, 72, 83, 1.000000); font:

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'>Elon Musk _$B64678B8-E74C-4529-9C3D-ACC61F57F1F8Ø !S$%&()UVQ[_Qc]isLeftAligned
*{-342.12936827959675, -168.58837365591398}Ò,WXXpathTypeÓ/01ŸY({0.863000, 0.133000,
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'>Peter Thiel _$BF6BE59B-4E04-418E-9A06-9B09B0941FA2Ø !e$%&()ghQmqQu]isLeftAligned
*{-353.09190273284912, -135.20009231567383}Ò,ijXpathTypeÓ/01Ÿk({0.863000, 0.133000,
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'>Tony Robbins _$CB6A0C2F-10A1-444C-9D68-1D1022E234F2Ø !‰$%&()‹ŒQ'•Q™]isLeftAligned
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'>Eric Schmidt _$71B816BB-8096-4A2E-B86D-F4ACFB55AC22Ø !›$%&()žQ£§Q«]isLeftAligned
*{-345.19909274197153, -38.938676075268859}Ò,Ÿ XpathTypeÓ/01Ÿ¡({0.863000, 0.133000,
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'>Lebron James _$EEB5533B-3B56-460F-9EEB-D1F5CBB311CF_{-703.3125, -
160.625}Ò,®¯XpathTypeÓ/012°_({0.863000, 0.133000, 0.157000,
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"Helvetica Neue"; text-align: center; -cocoa-font-postscriptname: "HelveticaNeue";
'>Business, Celebrity & Professional figures- VA Initiative support _$26A9AB63-
C385-48E0-81E2-98D92CE763B0_*{-1082.5780944824219, -
323.66541290283203}Ò,½¾XpathTypeÓ/01~¿_({0.863000, 0.133000, 0.157000,
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A5F9-EEDA12082924.pdfÓ=>?ÇÉÓ/01rÈ_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000,
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decoration: underline; -cocoa-font-postscriptname: "HelveticaNeue-Bold"; -cocoa-
underline: single; '>Storytelling & Mission Visibility: <span style='color:
rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; -cocoa-font-postscriptname:
"HelveticaNeue"; '>Partner with independent documentarians, artists and culturally
_$D54B30BC-0768-40DE-A8E2-FB2FE3A813E0Ù !#Ð$%&(Ñö÷ûQQ]isLeftAligned¢ÒäØ
!Ó$%&()ÕÖQÛßQã]isLeftAligned _{-847.3671875, -70.34375}Ò,×ØXpathTypeÓ/012Ù_({0.863000,
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72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: center; -cocoa-font-
postscriptname: "HelveticaNeue"; '>Co-invest at strategic partner to add value with VA

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core assets _$1EFD2076-CDF2-476E-9DBD-3867CD7C691DØ !å$%&()çèQíñQõ]isLeftAligned _){-846.68598790325495, 1.2914986559126191}Ò,éêXpathTypeÓ/012ë_({0.863000, 0.133000, 0.157000, 1.000000}Ó=>?îðÓ/01rï_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHó_Õ Prioritization to follow major VA focus areas (Amputation/PTSD etc.) _$A313C3A9-5F9B-4863-B51F-6077D35CC566_*{-1061.7656860351562, -157.54712104797363}Ò,øùXpathTypeÓ/01~ú_({0.863000, 0.133000, 0.157000, 1.000000}Õ8,67üQþ†ÿX{60, 60}_MNClipArt_Color_Progress3.pdf_(4A02812D-C41F-400C-A6AD-A4297B7380F9.pdfÓ=>?Ó/01r_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_è<p style='color: rgba(52, 72, 83, 1.000000); font: bold 18px "Helvetica Neue"; text-align: center; text-decoration: underline; -cocoa-font-postscriptname: "HelveticaNeue-Bold"; -cocoa-underline: single; '>Products & Services _$DAA93FA6-CC42-47CF-B6ED-F0FCD46F326E_*{-1336.6896306818167, -422.48686079546144}Ò,
XpathTypeÓ/01r_({0.863000, 0.133000, 0.157000, 1.000000}Õ8,67Q†X{60, 60}_MNClipArt_Color_Tools.pdf_(39555C04-71BC-4B77-86A1-16816F9124F7.pdfÓ=>?Ó/01r_({0.863000, 0.133000, 0.157000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_¾ Strategic Partnerships _$7A88370B-7B7B-4168-8D16-A37040C9A8BFÙ !#$%&(ÕÖÚQàäQè]isLeftAligned¥!3{ŸØ !"$%&()$%Q*.Q2]isLeftAligned _${-1207.2265625, -23.671508312225342}Ò,&'XpathTypeÓ/01~(_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?+-Ó/01r,_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH0_ª Full System redesign on how we approach Innovation to adopt a Developmentally Deliberate Organization (Radical Optimism) _$8DE83BD9-CF88-4C68-81E9-E97E8DDBC039Ø !4$%&(5lmQrvQz]isLeftAligned£6HZØ !7$%&()9:Q?CQG]isLeftAligned _{-838.40625, 125.53125}Ò,;<XpathTypeÓ/012=_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?@BÓ/01rA_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHEoñ Voluntary Performance Based initiatives offered to well performing VISN s, or individual providers _$35393D2E-45C6-44F9-8843-FD21C2C12C1AØ !I$%&()KLQQUQY]isLeftAligned _{-834.9453125, 224.1953125}Ò,MNXpathTypeÓ/012O_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?RTÓ/01rS_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHWoÃ VA central to define and price high volume episodes _$9EE56033-151A-4A75-AD09-F9477985CCE7Ø ![$%&()]^QcgQk]isLeftAligned _{-828.875, 292.3125}Ò,_`XpathTypeÓ/012a_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?dfÓ/01re_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHio

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unclaimed episodic risk available opened for bid by accredited general contractors (Veteran owned-start up opportunity) _$D9EF24C7-FF35-4D2C-BFD1-BCF8C8D06A5B_({-1203.716372282609, 105.71224987648213}Ò,noXpathTypeÓ/01~p_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?suÓ/01rt_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHx_ Create proprietary episode definitions logic for Long-Tail Bundles spreading service and delivery risk/severity/intensity over multiple durations _$EDCD3CEA-CC2E-4AA0-A999-745C86E6E89DØ !|$%&()~Q„ˆQŒ]isLeftAligned _${-1181.08984375, 270.29648900691711}Ò,€XpathTypeÓ/01~,_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?…‡Ó/01r†_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHŠ_ Payment Models Group initially tasked with model creation, data management, and access strategy(waivers or equiv.) _$EE30CBE7-9F8D-4AE2-BAB2-E98340C6CD8CØ !Ž$%&()'Q-šQž]isLeftAligned _{-1168.640625, 426.2421875}Ò,'"XpathTypeÓ/01~"_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?-™Ó/01r˜_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHœ_¾ Immersion based controlled psychedelic research _$51EF962C-2B55-4538-9769-AEEFF40580CEØ ! $%&(¡ÆÇQÌÐQÔ]isLeftAligned¢¢´Ø !£$%&()¥¦Q«¯Q³]isLeftAligned _){-803.09700520832894, 495.12239583330893}Ò,§¨XpathTypeÓ/012©_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?¬®Ó/01r-_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH±_ Match vets with local families of fallen vets to encourage mentorship opportunities for kids and purpose building for isolated vets _$6DD21027-FFAE-46EF-804A-52B5B04F3941Ø !µ$%&()·¸Q½ÁQÅ]isLeftAligned _){-812.37760416666379, 630.10026041664241}Ò,¹°XpathTypeÓ/012»_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?¾ÀÓ/01r¿_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÃ_ö Offer incentives through partnership or direct veteran compensation for assisting vets with ADL support _$671BD444-0B05-4A44-94D7-2735EAF53B47_){-1172.4947916666606, 499.263671874984 77}Ò,ÈÉXpathTypeÓ/01~Ê_({0.149000, 0.733000, 0.820000, 1.000000}Ó=>?ÍÏÓ/01rÎ_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÒoõ Vet s supporting Vets : Revolutionize community support networks by incentivizing recovered veterans to care for veterans in active rehabilitation ex. gig economy for meaning making activities _$1DF39C05-509B-4BEE-946E-E19C021E0A4D_${-1354.2265625, -32.477627840909122}Ò,×ØXpathTypeÓ/01rÙ_({0.149000, 0.733000, 0.820000, 1.000000}Õ8,67ÛQÝ†ÞX{60, 60}_MNClipArt_Color_Creativity.pdf_(DC40DF21-FF98-493C-9D35-3A7CE0ABE99F.pdfÓ=>?áãÓ/01râ_({0.149000, 0.733000, 0.820000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHæ_±<p style='color: rgba(52, 72, 83, 1.000000); font:

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bold italic 18px "Helvetica Neue"; text-align: center; -cocoa-font-postscriptname: "HelveticaNeue-BoldItalic"; '>Big Ideas _$51AF249B-5389-4732-9796-FB5C56E4EE19Ø !ê$%&(ë45:>QB]isLeftAligned¤ìþ"Ø !í$%&()ïðõùQý]isLeftAligned _*{-1921.1939913841984, -652.91450024676578}Ò,ñòXpathTypeÓ/01~ó_({0.992000, 0.714000, 0.051000, 1.000000}Ó=>?öøÓ/01r÷_({0.992000, 0.714000, 0.051000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHû_˜ Data Lake _$7E093661-8B5C-40DB-BF2E-03298CBCE308Ø !ÿ$%&()Q]isLeftAligned _*{-2017.8694937100972, -600.67195916944934}Ò,XpathTypeÓ/01~_({0.992000, 0.714000, 0.051000, 1.000000}Ó=>?
Ó/01r_({0.992000, 0.714000, 0.051000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH
¾<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>National Footprint of Service Delivery Capacity</p>$56049D74-810E-4C7D-A017-4EE4CAAE7783Ø !$%&()Q!]isLeftAligned _*{-1990.3053060552124, -536.941178598711 53}Ò,XpathTypeÓ/01~_({0.992000, 0.714000, 0.051000, 1.000000}Ó=>?Ó/01r_({0.992000, 0.714000, 0.051000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_ <p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>Captive Workforce</p>_$6168A7A4-9562-4F2D-AE6E-9A53E968D292Ø !#$%&()%&+/Q3]isLeftAligned _*{-2015.1094055175781, -496.63227844238281}Ò,'(XpathTypeÓ/01~)_({0.992000, 0.714000, 0.051000, 1.000000}Ó=>?,.Ó/01r-_({0.992000, 0.714000, 0.051000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH1_³<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>Largest Bio-Bank of Genetic Material</p>_$DC5E2DEA-AF18-4E34-BB99-CA7ADA54B82F_{-1624.953125, -501.2734375}Ò,67XpathTypeÓ/01r8_({0.992000, 0.714000, 0.051000, 1.000000}Ó=>?;=Ó/01r<_({0.992000, 0.714000, 0.051000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH@_´<p style='color: rgba(52, 72, 83, 1.000000); font: bold italic 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue-BoldItalic"; '>VA Core Assets</p>_$1FE5FC29-CA92-456A-A70B-12C4F5A422EEØ !D$%&(EEFKOQS]isLeftAligned¤FßñØ !G$%&(HÐÑÖÚQÞ]isLeftAligned¥I[m¾Ø !J$%&()LMRVQZ]isLeftAligned _*{-2225.2034912109375, -442.56076049804688}Ò,NOXpathTypeÓ/012P_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?SUÓ/01rT_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHX_ª<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>Upstream Suicide Prevention</p>_$33214D71-6973-4BAE-AFB1-7EB3C14E17E9Ø !\$%&()^_dhQl]isLeftAligned _*{-2273.3589172363281, -410.47673034667969}Ò,`aXpathTypeÓ/012b_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?egÓ/01rf_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHj_Ë<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>Destigmitize mental health and mental health engagement. </p>_$9BF97C1F-F028-473F-8EB5-0A63FDCC9416Ø !n$%&()pqvzQ~]isLeftAligned _*{-2175.5081176757812, -356.37271118164062}Ò,rsXpathTypeÓ/012t_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?wyÓ/01rx_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH|_ž<p style='color: rgba(52, 72, 83, 1.000000); font: 18px

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"Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>web-based PTSD _$077E7958-1DE8-40C8-ACC5-F7522C5282EAØ !€$%&(§¨-±Q½]isLeftAligned¡,Ø !ƒ$%&(„˜™ž¢Q¦]isLeftAligned¡…Ø !†$%&()ˆ‰"Q-]isLeftAligned _*{-2519.4877871788558, -279.76148983799862}Ò,Š‹XpathTypeÓ/01Œ#@_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?'Ó/01r'_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH•_© (Craigslist) Craig Newmark _$634E283E-291E-46D7-B543-879233697ABF_){-2237.907114624506, -297.09759717495524}Ò,š›XpathTypeÓ/01Ÿœ_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?Ÿ¡Ó/01r _({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH¤_ž Fellows Program _$FAA34BEA-6402-4EFD-9279-DC535C3CC9F9_*{-2063.3285522460938, -324.24370956420898}Ò,©ªXpathTypeÓ/012«_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?®°Ó/01r¯_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÔDEFGH²»ØJK1LMNOPQ´µQ·QQ#@2_({0.263000, 0.357000, 0.400000, 1.000000}]HelveticaNeueP_$1ED43F18-24C9-41B7-B588-67233EE57FB5Ø !¿$%&()ÁÂÇËQÏ]isLeftAligned _*{-2316.6292433305216, -229.99162899364126}Ò,ÃÄXpathTypeÓ/012Å_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?ÈÊÓ/01rÉ_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÍ_¨ 4 public one page studies _$EB450F4E-D44A-4B61-9199-7A6ABDAD44FC_*{-1947.3128551136363, -399.10475852272725}Ò,ÒÓXpathTypeÓ/01~Ô_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?×ÙÓ/01rØ_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÜ_¡ Innovators Network _$6DF95DC5-2652-4FDE-9B52-FD03D5C9E493Ø !à$%&()âãèìQð]isLeftAligned _*{-1952.2347301136363, -346.71413352272725}Ò,äåXpathTypeÓ/01~æ_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?éëÓ/01rê_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHî_¤ Industry Competitions _$CB7984CE-6565-44D2-AAEE-7B4C97DF4423Ø !ò$%&()ôõúþQ]isLeftAligned _*{-2076.9168090820312, -180.74679565429688}Ò,ö÷XpathTypeÓ/01~ø_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?ûýÓ/01rü_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH_° Special Projects (no information) _$9B83B77D-8500-4155-9C9A-79360832EB09Ø !$%&(67<@QD]isLeftAligned¢Ø !$%&()Q]isLeftAligned _*{-2024.4610595703125, -148.60707473754883}Ò,XpathTypeÓ/012_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?Ó/01r_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÔDEFGHØJK1LMNOPQ´Q·QQ_({0.263000, 0.357000, 0.400000, 1.000000}P_$C04959B0-1D63-4874-B630-4FF74078E5E2Ø !$%&()!"'+Q5]isLeftAligned _){-2019.6654510498047, 133.32208824157715}Ò,#$XpathTypeÓ/012%_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?(*Ó/01r)_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000,

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1.000000, 1.000000}ÔDEFGH,3ØJK1LMNOPQ´.Q·QQ_({0.263000, 0.357000, 0.400000, 1.000000}P_$DC1C8F6B-E466-48E7-B118-1E7BEA80942D_*{-1953.8232727050781, -148.61770820617676}Ò,89XpathTypeÓ/01~:_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?=?Ó/01r>_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHB_› Partnerships _$FC1ED451-BEF0-4532-803E-C8AD8835BAE8_*{-1727.5667613636363, -417.22585227272725}Ò,GHXpathTypeÓ/01rI_({0.071000, 0.529000, 0.871000, 1.000000}Ó=>?LNÓ/01rM_({0.071000, 0.529000, 0.871000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHQ_² 2010-Present _$A08B2F2C-71DD-4E82-BFCC-E1B3ECD55C88Ù !#U$%&(VçèìòöQú]isLeftAligned¨Wi{Ÿ±ÃÕØ !X$%&()Z[`dQh]isLeftAligned _){-1841.8751575100805, 50.077657996966991}Ò,\]XpathTypeÓ/01~^_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?acÓ/01rb_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHf_˜ Community _$674DD8BB-BAA6-43D4-BD48-768B159D9FABØ !j$%&()lmrvQz]isLeftAligned _({-1854.020787392893, 82.158980666949901}Ò,noXpathTypeÓ/01~p_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?suÓ/01rt_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHx_ž Physical Health _$3D496452-B6D0-4F74-9A34-0784E1801E5BØ !|$%&()~„ˆQŒ]isLeftAligned _){-1814.6398059475805, 114.23071414168135}Ò,€XpathTypeÓ/01~,_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?…‡Ó/01r†_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHŠ_- Wellness _$68D6342F-0F38-4FBA-9DD7-03D7CC05E839Ø !Ž$%&()'-šQž]isLeftAligned _){-1860.3933765042211, 146.30467921431318}Ò,'"XpathTypeÓ/01~"_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?-™Ó/01r˜_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHœ_š Mindfulness _$3290DD9D-B305-408C-B0D0-826E115A9B2AØ ! $%&()¢£¨¬Q°]isLeftAligned _){-1861.4018603909399, 178.39271098311201}Ò,¤¥XpathTypeÓ/01~¦_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?©«Ó/01rª_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGH®_˜ Education _$475ABB4E-EA72-4914-ADAA-E7CBFE880D7DØ !²$%&()´µ°¾QÂ]isLeftAligned _({-1913.914097939768, 210.50485163862959}Ò,¶·XpathTypeÓ/01~¸_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?»½Ó/01r¼_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÀ_Ÿ Entrepreneurship _$F13BB5C7-9E85-4D1B-BCAB-F765F304D608Ø !Ä$%&()ÆÇÌÐQÔ]isLeftAligned _){-[redacted]
267.65415318806936}Ò,ÈÉXpathTypeÓ/01~Ê_({0.220000, 0.576000, 0.216000, 1.000000}Ó=>?ÍÏÓ/01rÎ_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHÒ_¯<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue";

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'>Transparency & Communication</p>_$EA04FB77-50E9-4207-993D-88D49AD39EE1Ø
!Ö$%&()ØÙÞâQæ]isLeftAligned _){-2052.3566333401591,
311.41100467148635}Ò,ÚÛXpathTypeÓ/01~Ü_({0.220000, 0.576000, 0.216000,
1.000000}Ó=>?ßáÓ/01rà_({0.220000, 0.576000, 0.216000, 1.000000}_({1.000000, 1.000000,
1.000000, 1.000000}ÓDFGHä_¬<p style='color: rgba(52, 72, 83, 1.000000); font: 18px
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'>Progressive Behavioral Health</p>_$90B840C8-5DEA-4B62-B789-8F3853719F23_*{-
1681.5458011921462, -55.727960210007154}Ò,éêXpathTypeÓ/01rë_({0.220000, 0.576000,
0.216000, 1.000000}Õ8,67íQï†ðX{60, 60}_MNClipArt_Color_SignHeart.pdf_(E28EB639-3CE7-
4798-ABD8-2B652A83FAB2.pdfÓ=>?óõÓ/01rô_({0.220000, 0.576000, 0.216000,
1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFGHø_À<p style='color: rgba(52,
72, 83, 1.000000); font: bold italic 18px "Helvetica Neue"; text-align: center; -cocoa-
font-postscriptname: "HelveticaNeue-BoldItalic"; '>Strategic Re-Focus
Areas</p>_$DC7F7B0F-B067-4760-AE10-D2CBF6DD5E29Ù !#ü$%&(ýjkouyQ}]isLeftAligned¡þØ
!ÿ$%&([\aeQi]isLeftAligned£IØ !$%&()
Q]isLeftAligned _{-2041.5, 486.125}Ò,XpathTypeÓ/012_({0.573000, 0.165000, 0.647000,
1.000000}Ó=>?
Ó/01r_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000, 1.000000, 1.000000,
1.000000}ÓDFGH_•<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica
Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue";
'>Trusts</p>_$C2B9DE2D-5582-4354-A016-563F6ED714BDØ !$%&(:;@DQH]isLeftAligned¢(Ø
!$%&()#Q']isLeftAligned _({-2300.1107190860116,
508.5176411290438}Ò,XpathTypeÓ/01Ÿ_({0.573000, 0.165000, 0.647000, 1.000000}Ó=>?
"Ó/01r!_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000, 1.000000, 1.000000,
1.000000}ÓDFGH%_œ<p style='color: rgba(52, 72, 83, 1.000000); font: 18px "Helvetica
Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue"; '>Walton
Family</p>_$3B203B4D-1806-4376-A7E4-750736EECE88Ø !)$%&()+,15Q9]isLeftAligned _){-
2275.6142473118175, 539.69623655915143}Ò,-.XpathTypeÓ/01Ÿ/_({0.573000, 0.165000,
0.647000, 1.000000}Ó=>?24Ó/01r3_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000,
1.000000, 1.000000, 1.000000}ÓDFGH7_"<p style='color: rgba(52, 72, 83, 1.000000); font:
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536.6328125}Ò,<=XpathTypeÓ/012>_({0.573000, 0.165000, 0.647000,
1.000000}Ó=>?ACÓ/01rB_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000, 1.000000,
1.000000, 1.000000}ÓDFGHF_<p style='color: rgba(52, 72, 83, 1.000000); font: 18px
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'>Family Offices</p>_$3EFF1789-70EA-4100-9906-931D02F8845EØ !J$%&()LMRVQZ]isLeftAligned
{-2251.6328125, 586.3984375}Ò,NOXpathTypeÓ/012P({0.573000, 0.165000, 0.647000,
1.000000}Ó=>?SUÓ/01rT_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000, 1.000000,
1.000000, 1.000000}ÓDFGHX_©<p style='color: rgba(52, 72, 83, 1.000000); font: 18px
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'>Venture & PE Community</p>_$FF0CEC19-5F43-4D4E-A2A2-026DB00609FC_{-1911.9453125,
372.6171875}Ò,]^XpathTypeÓ/01~__({0.573000, 0.165000, 0.647000,
1.000000}Ó=>?bdÓ/01rc_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000, 1.000000,
1.000000, 1.000000}ÓDFGHg_Ì<p style='color: rgba(52, 72, 83, 1.000000); font: 18px
"Helvetica Neue"; text-align: left; -cocoa-font-postscriptname: "HelveticaNeue";
'>Models for sharing execution risk withoutside capital sources</p>_$B7B72D4D-67CE-
4493-8378-EB336FCB50A0_{-1583.4765625, 258.046875}Ò,lmXpathTypeÓ/01rn_({0.573000,

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0.165000, 0.647000, 1.000000}Õ8,67pQr†sX{60,
60}_MNClipArt_Color_Finances.pdf_(20E18094-C11C-4E2F-9791-
7B67BB1CEFF0.pdfÓ=>?vxÓ/01rw_({0.573000, 0.165000, 0.647000, 1.000000}_({1.000000,
1.000000, 1.000000, 1.000000}ÓDFGH{_¼<p style='color: rgba(52, 72, 83, 1.000000); font:
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"HelveticaNeue-BoldItalic"; '>Capital & Access</p>_$F30A4EF9-ABC4-4A17-957C-
4C22D42E46B6_*{-1568.2638092041016, -172.08699521151459}Ò,€XpathTypeÓ/012,_({0.102000,
0.333000, 0.412000, 1.000000}Ó=>?9…‡Ó/01†_({1.000000, 1.000000, 1.000000,
1.000000}_({1.000000, 1.000000, 1.000000, 1.000000}ÓDFG‰Q‹#@q_À<p style='color:
rgba(22, 67, 85, 1.000000); font: 24px "Helvetica Neue"; text-align: center; -cocoa-
font-postscriptname: "HelveticaNeue-Light"; '>Veterans Administration Innovation
Center</p>_$C0E5A915-0A41-4961-9AAC-9D8C138CE9EFÚ !#$%&'()""˜™œ
Q«[layoutStyle_decreasingStrokeWidth _*{-2360.6074642058338, -148.34157142939628}Ò,•-
XpathTypeÓ/012-_({0.102000, 0.333000, 0.412000, 1.000000}Ó6789š›_(BCFF11BF-CEC6-49B9-
9F1F-B5D6DCF8A58A.png_{300, 130.232558139534 89}Ó=>?9ŸÓ/01ž_({1.000000, 1.000000,
1.000000, 1.000000}_({1.000000, 1.000000, 1.000000,
1.000000}ÔDEFGH¡¨ØJK1LMNOPQR£QUQQ_({0.102000, 0.333000, 0.412000, 1.000000}P_$829BD051-
BCB1-42B8-8783-64F1FF82AD5FÚ !-#$%&®()°±µ¶¹½QÈ[layoutStyle_decreasingStrokeWidth _){-
2356.7491760253906, 56.786535444050813}Ò,²³XpathTypeÓ/012´_({0.102000, 0.333000,
0.412000, 1.000000}Ó6789·¸_(D781D34B-D9D0-4A66-93A2-718082B28251.png_{300,
174.74452554744525}Ó=>?9°¼Ó/01»_({1.000000, 1.000000, 1.000000, 1.000000}_({1.000000,
1.000000, 1.000000, 1.000000}ÔDEFGH¾ÅØJK1LMNOPQRÀQUQQ_({0.102000, 0.333000, 0.412000,
1.000000}P_$2F63E7FF-D6BB-4F24-A35D-A9BB0046C2F5 _({0.906000, 0.922000, 0.933000,
1.000000}%-9ACEjƒ¦¾É×î()6@SYb‹"Ş³¾ÉÏãû09EN[`flu ¢¯´½ÂÄïù$.;f'¢«µÊÏØù
*49:Cno…†‡^‰Š‹²×ãû-;Diwz›©ªÈÑÚç -6aŒ™š''¹æïø9NUajk‹¸¹ÆÓþ)67bcŠ¯½Âãñô#$BKTaj•-£°Û

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,WXerÈÕÖ‹Œ³àéòÿ*?HIf''Ÿ¬×KLs˜¦-ÎÜß<EN[†‡"¡Ì÷ÆÇî*UVcp›ÆÓÔ ¡Èé÷ø(5`an{¦ÑÞß´µÜý;IJv^•ÀÁÎÛ
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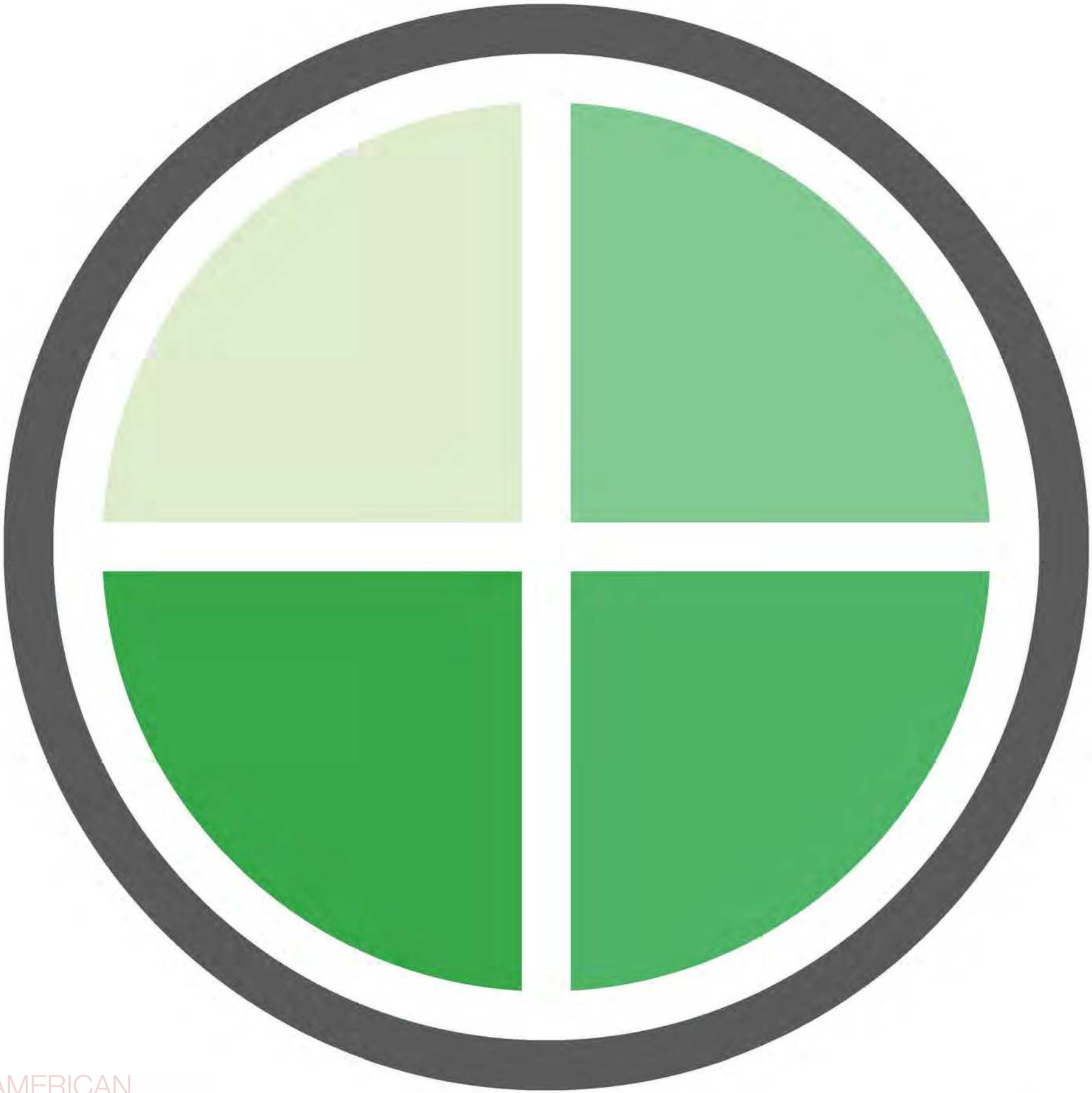

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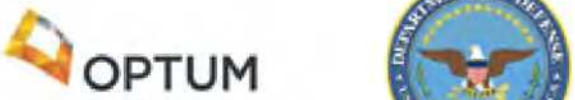





















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Got Your Six

Since 2013 VACI has partnered with Got Your Six to present Storytellers, a thought leadership symposium for sharing the unique stories of Veterans working in innovative fields and having a profound impact on the civilian world.

Walgreens

As a result of this partnership, Veterans now have the option to electronically forward their immunization records from Walgreens to VA, relieving them of the need to complete additional forms or remember to provide the information to their local VA providers.

Unite US

VACI has partnered with Unite US to explore new approaches to outreach and engagement at the local level, enabling small VA teams to do direct, real-time outreach with Veterans in their communities.

TechShop

VACI collaborated with TechShop to provide 2,000 one-year memberships at six TechShop locations across the U.S., providing Veterans with free access to cutting-edge training and equipment to become more competitive in the job market or pursue entrepreneurial goals.

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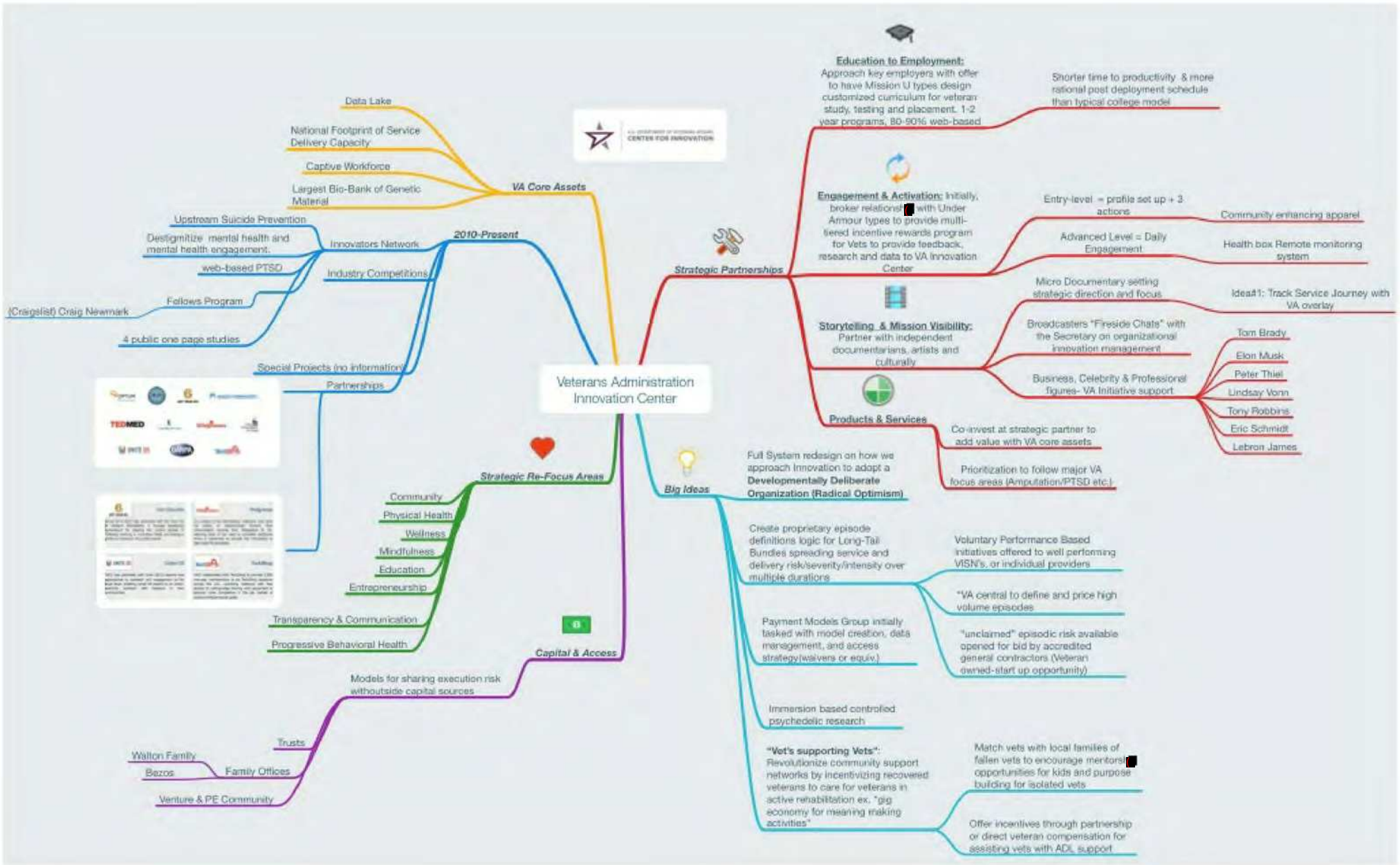

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/13/2017 9:59:47 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: drshulkin@aol.com
Subject: Re: Home - Malone Center for Engineering in Healthcare

Sounds good Bruce- looking forward to it.

Sent from my iPad

> On Apr 12, 2017, at 1:35 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Dr. (b) (6) is Mandela Bellmore Professor of Computer science and I will have an initial call to see if we can get their innovative technology center to provide their expertise as a service to their Country and the VA.
> https://malonecenter.jhu.edu/
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/12/2017 7:47:24 PM
To: Charlie Wiggins [(b) (6) remedyventures.com]
Subject: Re: Home - Malone Center for Engineering in Healthcare

Ok great

Sent from my iPhone

On Apr 12, 2017, at 3:37 PM, Charlie Wiggins <(b) (6) remedyventures.com> wrote:

> The Malone center is onto some interesting work - the Galen System, microsurgical robotics platform and the Kata Studio - are two that stick out as being beneficial for patients and clinicians within the VA.
>
> I have only spoke with the White House Liaison to the VA, (b) (6) yesterday and submitted all the necessary documentation here: https://apply.ptt.gov/
> (b) (6) also has a copy of the attached Bio, so I suspect he will be moving the process along.
>
> Please let me know what else I can do to be helpful to your internal process.
>
> Thanks for sharing,
>
> Charlie
>
> On Wed, Apr 12, 2017 at 1:48 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > More good stuff
> >
> > Has anyone cobtacted you from VA
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **Date:** April 12, 2017 at 1:34:43 PM EDT
> > **To:** drshulkin@aol.com, Poonam Alaigh <(b) (6) hotmail.com>
> > **Subject: Home - Malone Center for Engineering in Healthcare**
> >
> > Dr. (b) (6) is Mandela Bellmore Professor of Computer science and I will have an initial call to see if we can get their innovative technology center to provide their expertise as a service to their Country and the VA.
> > https://malonecenter.jhu.edu/
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.

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--
Charles Wiggins
203.856.(b)

<SKC_SES Bio Sheet PDF.pdf>

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Message

From: Charlie Wiggins [(b) (6) remedyventures.com]
Sent: 4/12/2017 7:37:36 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Home - Malone Center for Engineering in Healthcare
Attachments: SKC_SES Bio Sheet PDF.pdf

The Malone center is onto some interesting work - the Galen System, microsurgical robotics platform and the Kata Studio - are two that stick out as being beneficial for patients and clinicians within the VA.

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Please let me know what else I can do to be helpful to your internal process.

Thanks for sharing,

Charlie

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>
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> **To:** drshulkin@aol.com, Poonam Alaigh <(b) (6) hotmail.com>
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> https://malonecenter.jhu.edu/
>
> Sent from my iPad
> Bruce Moskowitz M.D.

--
Charles Wiggins
203.856.(b)

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The White House
Presidential Personnel Office

SKC/SES BIO SHEET

NOTICE: Return this form to the Presidential Personnel Office as soon as complete. This information is necessary to begin the clearance process. Return to White House Liaison when completed.

PART I: PERSONAL INFORMATION (TO BE COMPLETED BY THE CANDIDATE)

1. FULL NAME (Last, First, Middle):	2. SOCIAL SECURITY NUMBER:
Wiggins, Charles, Anthong	(b) (6) [redacted]

3. CURRENT RESIDENTIAL ADDRESS (Number, Street, City, State, ZIP Code)
(b) (6) [redacted] H [redacted]

4. VOTING ADDRESS IN 2016 (Number, Street, City, State, ZIP Code, if different than current address)
(b) (6) [redacted] L [redacted] 0 [redacted]

5. PLACE OF BIRTH (City, State; if not U.S., state, country)	6. GENDER	7. DATE OF BIRTH
(b) (6) [redacted]	Male	(b) (6) [redacted]

8. ETHNIC HERITAGE	9. RACE	10. POLITICAL PARTY
90% Scottish/Irish 10%Hungarian	White	(b) (6) [redacted]

11. HOME PHONE	12. CELL PHONE	13. WORK PHONE
(b) (6) [redacted]	2038567662	2038567662

14. PERSONAL EMAIL	15. WORK EMAIL
(b) (6) [redacted] remedyventures.com	(b) (6) [redacted] remedyventures.com

16. CURRENT POSITION (Title, Company)	17. WORK ADDRESS (Number, Street, City, State, Zip)
CEO, Second Cycle	160 14th Street, San Francisco, CA 94103

18. PLEASE LIST ALL SOCIAL MEDIA ACCOUNTS (Or say none if you have none)
https://www.linkedin.com/in/charles-wiggins-016bb833/

19. EDUCATION (Degree, Institution, Year)	20. AWARDS
BA, University of Maryland, 2008 MHA, Johns Hopkins University, 2011	1st-team All-American ACC-Champion

21. MILITARY SERVICE (Rank, Branch, Years)	22. PREVIOUS PRESIDENTIAL APPOINTMENTS

PART II: POSITION INFORMATION (TO BE COMPLETED BY WHITE HOUSE LIAISON)

1. POSITION TITLE	2. AGENCY

2. APPOINTMENT TYPE	3. GRADE	4. OPM NUMBER

5. WH LIAISON NAME	6. WH LIAISON PHONE	7. WH LIAISON EMAIL

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/12/2017 5:48:16 PM
To: Charlie Wiggins [(b) (6) remedyventures.com]
Subject: Fwd: Home - Malone Center for Engineering in Healthcare

More good stuff

Has anyone cobtacted you from VA
Sent from my iPhone

Begin forwarded message:

> **Date:** April 12, 2017 at 1:34:43 PM EDT
> **To:** drshulkin@aol.com, Poonam Alaigh <(b) (6) hotmail.com>
> **Subject: Home - Malone Center for Engineering in Healthcare**
>
> Dr. (b) (6) is Mandela Bellmore Professor of Computer science and I will have an initial call to see if we can get their innovative technology center to provide their expertise as a service to their Country and the VA.
> https://malonecenter.jhu.edu/
>
> Sent from my iPad
> Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/12/2017 5:47:35 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Home - Malone Center for Engineering in Healthcare

Great

Sent from my iPhone

> On Apr 12, 2017, at 1:34 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Dr. (b) (6) is Mandela Bellmore Professor of Computer science and I will have an initial call to see if we can get their innovative technology center to provide their expertise as a service to their Country and the VA.
> https://malonecenter.jhu.edu/
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/12/2017 5:34:43 PM
To: drshulkin@aol.com; Poonam Alaigh [(b) (6) hotmail.com]
Subject: Home - Malone Center for Engineering in Healthcare

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https://malonecenter.jhu.edu/

Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 1:25:16 AM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: Curt Cashour

Excellent
I thought so

Sent from my iPhone

> On Apr 18, 2017, at 9:20 PM, Darin Selnick <(b) (6) k@gmail.com> wrote:
>
> I did some checking on Curt, talked to a few people and (b) (6), (b) (2)
>
> I think you have a winner in Curt.
>
> Darin

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/9/2017 10:43:32 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: VA - EPIC
Attachments: Advisory Committee On Veterans Healthcare.03.9.2017.docx; Untitled attachment 05084.htm; Contact Information.docx; Untitled attachment 05087.htm

Just between us of course

Sent from my iPhone

Begin forwarded message:

From: "IP" <(b) (6) frenchangel59.com>
Date: April 9, 2017 at 6:15:35 PM EDT
To: "David shulkin" <drshulkin@aol.com>
Subject: FW: VA - EPIC

From: IP [mailto (b) (6) frenchangel59.com]
Sent: Sunday, April 09, 2017 6:12 PM
To: (b) (6) who.eop.gov'
Cc: (b) (6) who.eop.gov; Ivanka Kushner ((b) (6) (b) (6) Iper (b) (6) @gmail.com
Subject: VA - EPIC

(b) (6)

It was pleasure meeting and having dinner with you last night. We very much look forward to working with you on the VA.

A little more background on EPIC.

The DOD recently signed a new contract to implement a new system called Cerner with an initial cost of $4.3 billion and a total budgeted cost of $9 billion. As I mentioned last night, there is a push for the VA to choose the same Cerner system. What the VA needs is a system that can speak to the private hospitals' systems with which it will be partnering for Veterans medical care (interoperability among the Public-Private Partnership).

The top 5 Academic Medical Centers do not use Cerner and highly recommend against using it, and instead strongly favor using another system called EPIC. EPIC is used by 50% of the hospitals in the US and covers over 120 million patients. Using EPIC, therefore, as the VA platform will allow seamless integration with the platform of the majority of community and academic medical centers. As a result, when veterans access care outside the VA system (the choice extension) there will be the necessary access and integration to vital medical information. This means less cost, easier access to the doctors, patients and veterans and their medical records.

In addition, the VA's doctors and doctors in training who come from the academic medical centers and who practice part time at the VA have been trained on and use EPIC. It would be

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impractical to expect them to learn two different systems. Also, the VA conducts medical research with academic medical centers across the nation, and using something other than EPIC would make many vital research projects more costly to integrate and collect data.

The VA has confirmed that they are on same page to pursue EPIC as their EMR of choice, instead of Cerner.

Cerner has claimed that its system cannot talk to EPIC if the VA chooses EPIC. We, however, believe that EPIC will allow for this cross talk. We also believe that the ability of working with the two different platforms is, in reality, an artificial barrier by Cerner that can be resolved if they choose.

As I discussed yesterday, the best solution is for the DOD to change to EPIC, for the good of the DOD, the soldiers, the VA and our veterans. However, if that is not in the cards, then It is **CRITICAL that Cerner be mandated** to design its DOD system to talk to (be able to share medical records with) whatever system the VA chooses to install. **It is very important that this is resolved quickly at the DOD/Cerner level by instructions from the White House.**

If you think it will be beneficial for you to talk directly to the experts at the Academic Medical Centers, you can call one of the people working on the VA effort with me, Dr. Bruce Moskowitz, and he will be happy to arrange discussions with the head IT leaders at any or all of the top 5 academic medical centers so you can hear their points of view and perspectives on this topic directly. Bruce's phone number is (561) 346-(b) (6) and his email is (b) (6) @mac.com .

I have also attached my contact information.

Regards,

Ike

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ADVISORY
ON VETERANS HEALTH CARE

1. Dr. David Shulkin, Secretary for Health for the Department of Veterans Affairs
2. Dr. [redacted] President and CEO of the Cleveland Clinic
3. Dr. [redacted] President and CEO of the Mayo Clinic
4. [redacted] Chair Department of Public Affairs of the Mayo Clinic
5. Dr. [redacted] President and CEO of Partners HealthCare (Massachusetts General and Brigham and Women's Hospitals)
6. Dr. [redacted] Dean and CEO of Johns Hopkins Medicine
7. Marc. B. Sherman, Senior Partner at international business restructuring and financial consulting firm Alvarez & Marsal
8. [redacted] Chairman and CEO of Kaiser Foundation Health Plan, Inc. and Hospitals — known as Kaiser Permanente, one of America's leading integrated health care providers and not-for-profit health plans.
9. Dr. Bruce Moskowitz, who has observed in frustration over his years as a noted Palm Beach physician in private practice the crucial need to overhaul our system of delivering veterans' health care.
10. [redacted] is the wife of injured Purple Heart Veteran, co-founder of Hope Unseen, mother, nurse BSN, news contributor, speaker and believe that there is always joy to be uncovered.
11. Laura ("Laurie") Perlmutter, a member of the Board of Trustees of NYU Langone Medical Center and of the Board of Advisors of the Laura & Isaac Perlmutter Cancer Center at NYU Langone, which she established with her husband Isaac Perlmutter.
12. Isaac ("Ike") Perlmutter, a self-made and highly successful business leader and member of the Board of Trustees of NYU Langone whose support for medical research and care has included the establishment, with his wife Laura of the Perlmutter Cancer Center at NYU Langone.

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Our contact Information below:

Laurie Perlmutter
561-585-[redacted] (Home)
561-818-[redacted] (Cell)
Email: [redacted]gmail.com

Ike Perlmutter
561-586-[redacted] (Home)
561-685-[redacted] (Cell) ***Please note I rarely keep the cell "ON" – If you can't reach me call Marisol – Marisol is able to find me any time.***
Email: [redacted]frenchangel59.com

Assistant: Marisol Garcia
212-576-[redacted] (Office)
212-576-[redacted] (Weekend Office)
Cell: 646-668-[redacted] (Marisol's Cell)
Email: [redacted]frenchangel59.com

Please feel free to email or call us any time.

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Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/9/2017 10:15:35 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: VA - EPIC
Attachments: Advisory Committee On Veterans Healthcare.03.9.2017.docx; Contact Information.docx

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From: IP [mailto:(b) (6)frenchangel59.com]
Sent: Sunday, April 09, 2017 6:12 PM
To: (b) (6) who.eop.gov'
Cc: (b) (6) who.eop.gov; Ivanka Kushner ((b) (6) (b) (6) (b) (6) gmail.com
Subject: VA - EPIC

(b) (6)

It was pleasure meeting and having dinner with you last night. We very much look forward to working with you on the VA.

A little more background on EPIC.

The DOD recently signed a new contract to implement a new system called Cerner with an initial cost of $4.3 billion and a total budgeted cost of $9 billion. As I mentioned last night, there is a push for the VA to choose the same Cerner system. What the VA needs is a system that can speak to the private hospitals' systems with which it will be partnering for Veterans medical care (interoperability among the Public-Private Partnership).

The top 5 Academic Medical Centers do not use Cerner and highly recommend against using it, and instead strongly favor using another system called EPIC. EPIC is used by 50% of the hospitals in the US and covers over 120 million patients. Using EPIC, therefore, as the VA platform will allow seamless integration with the platform of the majority of community and academic medical centers. As a result, when veterans access care outside the VA system (the choice extension) there will be the necessary access and integration to vital medical information. This means less cost, easier access to the doctors, patients and veterans and their medical records.

In addition, the VA's doctors and doctors in training who come from the academic medical centers and who practice part time at the VA have been trained on and use EPIC. It would be impractical to expect them to learn two different systems. Also, the VA conducts medical research with academic medical centers across the nation, and using something other than EPIC would make many vital research projects more costly to integrate and collect data.

The VA has confirmed that they are on same page to pursue EPIC as their EMR of choice, instead of Cerner.

Cerner has claimed that its system cannot talk to EPIC if the VA chooses EPIC. We, however, believe that EPIC will allow for this cross talk. We also believe that the ability of working with the two different platforms is, in reality, an artificial barrier by Cerner that can be resolved if they choose.

As I discussed yesterday, the best solution is for the DOD to change to EPIC, for the good of the DOD, the soldiers, the VA and our veterans. However, if that is not in the cards, then It is **CRITICAL that Cerner be mandated** to design its DOD system to talk to (be able to share medical records with) whatever system the VA

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chooses to install. **It is very important that this is resolved quickly at the DOD/Cerner level by instructions from the White House.**

If you think it will be beneficial for you to talk directly to the experts at the Academic Medical Centers, you can call one of the people working on the VA effort with me, Dr. Bruce Moskowitz, and he will be happy to arrange discussions with the head IT leaders at any or all of the top 5 academic medical centers so you can hear their points of view and perspectives on this topic directly. Bruce's phone number is (561) 346-[redacted] and his email is [redacted]mac.com .

I have also attached my contact information.

Regards,

Ike

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ADVISORY
ON VETERANS HEALTH CARE

1. Dr. David Shulkin, Secretary for Health for the Department of Veterans Affairs
2. Dr. [redacted] President and CEO of the Cleveland Clinic
3. Dr. [redacted] President and CEO of the Mayo Clinic
4. [redacted] Chair Department of Public Affairs of the Mayo Clinic
5. Dr. [redacted] President and CEO of Partners HealthCare (Massachusetts General and Brigham and Women's Hospitals)
6. Dr. [redacted] Dean and CEO of Johns Hopkins Medicine
7. Marc. B. Sherman, Senior Partner at international business restructuring and financial consulting firm Alvarez & Marsal
8. [redacted] Chairman and CEO of Kaiser Foundation Health Plan, Inc. and Hospitals — known as Kaiser Permanente, one of America's leading integrated health care providers and not-for-profit health plans.
9. Dr. Bruce Moskowitz, who has observed in frustration over his years as a noted Palm Beach physician in private practice the crucial need to overhaul our system of delivering veterans' health care.
10. [redacted] is the wife of injured Purple Heart Veteran, co-founder of Hope Unseen, mother, nurse BSN, news contributor, speaker and believe that there is always joy to be uncovered.
11. Laura ("Laurie") Perlmutter, a member of the Board of Trustees of NYU Langone Medical Center and of the Board of Advisors of the Laura & Isaac Perlmutter Cancer Center at NYU Langone, which she established with her husband Isaac Perlmutter.
12. Isaac ("Ike") Perlmutter, a self-made and highly successful business leader and member of the Board of Trustees of NYU Langone whose support for medical research and care has included the establishment, with his wife Laura of the Perlmutter Cancer Center at NYU Langone.

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Our contact Information below:

Laurie Perlmutter
561-585-1571 (Home)
561-818-3073 (Cell)
Email: [redacted]gmail.com

Ike Perlmutter
561-586-6707 (Home)
561-685-8824 (Cell) ***Please note I rarely keep the cell "ON" – If you can't reach me call Marisol – Marisol is able to find me any time.***
Email: [redacted]frenchangel59.com

Assistant: Marisol Garcia
212-576-[redacted] (Office)
212-576-[redacted] (Weekend Office)
Cell: 646-668-[redacted] (Marisol's Cell)
Email: [redacted]frenchangel59.com

Please feel free to email or call us any time.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/1/2017 12:34:16 AM
To: (b) (6) [(b) (6) erwin@va.gov]
CC: (b) (6) [(b) (6) va.gov]; Poonam Alaigh [(b) (6) hotmail.com]

Can you reach out to verna, (b) (6) and (b) (6) w and see if they are able to join me and dr alaigh for a dinner mobday (tommorow night) at 630 pm at the source (at nuseum) to informally discuss choice - i know its no notice but its my only open evening for a while- we will go if 1,2 or all 3 are able to join

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/10/2017 10:30:11 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: VA & Epic Core Competencies in Healthcare - Draft

Bruce- ill call you on tuesday

Happy Passover

David

Sent from my iPhone

On Apr 10, 2017, at 12:57 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> I had an excellent call with (b) (6) and her staff. They are ready to move forward with the integration idea that we discussed on Friday. Second they are in favor of a system that allows a total open platform that any EMR can freely exchange records with. They believe that the Veteran should have the ability to have medical records sent to or sent from any EMR system. Third they will donate as a service to the Country their expertise in prevention of the opioid addiction, maternal health, mental health and a medical device registry.
> I would suggest you contact them to move forward. Thank you
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) epic.com>
> **Date:** April 10, 2017 at 12:33:34 PM EDT
> **To:** "(b) (6) mac.com" <(b) (6) mac.com>
> **Cc:** (b) (6) <(b) (6) epic.com>, (b) (6) <(b) (6) epic.com>
> **Subject: VA & Epic Core Competencies in Healthcare - Draft**
>
> <VA & Epic - Core Competencies in Healthcare V10.docx>

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/10/2017 4:57:22 PM
To: David Shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]
CC: (b) (6) (b) (6) @epic.com]; (b) (6) [(b) (6) epic.com]; (b) (6) (b) (6) @epic.com]
Subject: Fwd: VA & Epic Core Competencies in Healthcare - Draft
Attachments: VA & Epic - Core Competencies in Healthcare V10.docx; Untitled attachment 05099.htm

I had an excellent call with (b) (6) and her staff. They are ready to move forward with the integration idea that we discussed on Friday. Second they are in favor of a system that allows a total open platform that any EMR can freely exchange records with. They believe that the Veteran should have the ability to have medical records sent to or sent from any EMR system. Third they will donate as a service to the Country their expertise in prevention of the opioid addiction, maternal health, mental health and a medical device registry.
I would suggest you contact them to move forward. Thank you
Sent from my iPad
Bruce Moskowitz M.D.

Begin forwarded message:

From: (b) (6) <(b) (6) epic.com>
Date: April 10, 2017 at 12:33:34 PM EDT
To: "(b) (6) mac.com" <(b) (6) mac.com>
Cc: (b) (6) <(b) (6) epic.com>, (b) (6) <(b) (6) epic.com>
Subject: VA & Epic Core Competencies in Healthcare - Draft

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Department of Veterans Affairs: Core Competencies in Healthcare

Core Competency	VA Experience	Epic Experience
Size and Complexity	**Scalability and Performance** The VA is the largest integrated healthcare delivery system in the U.S with over 1,700 sites of care. The VA has over 20,000 beds across 168 VA Medical Centers and completes over 100 million outpatient appointments annually. The VA serves more than 8.9 million Veterans each year.	**Epic Footprint** The largest integrated civilian health systems in the U.S. run Epic, such as Kaiser Permanente, Sutter, Mayo Clinic, Partners, and Providence. • Kaiser Permanente serves over 11.3 million members across 38 hospitals and 661 clinics. • Over 336,000 physicians use Epic. • 57% of US population has a chart in Epic.
Lifetime Care	**Supporting Veterans at Every Stage** The VA supports the entire continuum of care for all 22 million veterans, from the time they first see the veteran to death. VA provides services to treat all medical needs of a veteran throughout their lifetime, including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology and physical therapy. Most VA medical centers offer specialty services including audiology, dermatology, dental, geriatrics, neurology, oncology, prosthetics, urology, and vision.	**A Full Suite of Products** EpicCare clinical systems provide a single healthcare platform to support a lifetime's worth of care for the veteran. Regardless of when or where the patient is seen at the VA, the clinician have access to the entirety of the patient chart. Modules for specialty care like Wisdom (dental), Cupid (cardiology), and Kaleidoscope (vision) are included as part of the enterprise Epic platform. Veterans and their caregivers have 24/7 access to the MyChart Patient Portal, allowing them to check lab results, message clinicians, request an appointment, and much more.
The Best Care	**Providing Quality** The VA is a benchmark of excellence, value in health care and benefits by providing exemplary services that are both patient-centered and evidence-based. Veterans think highly of VA healthcare too. In 2015, the VA scored an 86 and 80 for inpatient and outpatient in customer service satisfaction, respectively, compared to an average of customer service satisfaction score of 74 across private sector hospitals.	**The Best EHR Software** Epic software helps organizations deliver the best possible care to patients. • Truven Top 100 – more hospitals use Epic than any other system. • Leapfrog Top Hospitals for Quality and Safety – more hospitals use Epic than any other vendor. • KLAS surveys – healthcare organizations rank Epic as having the #1 software suite each year for the last seven years.
Choice Of Care	**Retaining the Veteran Customer Base** With the expansion of the Choice Act, veterans now have more options to see care outside of the VA. VA retains its patient base by being the best. VA provides value in health care, superb customer service, and cutting edge care and technology to keep veterans coming back to VA for their healthcare.	**Patients Notice the Best Software** Epic software keeps patients coming back. *Customer Success:* • A Kaiser Permanente study showed MyChart positively impacts patient loyalty and member satisfaction. Users are 2.6 times more likely than nonusers to remain KP members. 85% of users rate email encounters an 8 or a 9 on a 9-point scale.

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Suicide Prevention	**Decreasing Veteran Suicides** An average of 20 veterans die from suicide each day. As a leader in evidence-based care for suicide prevention, VA utilizes risk scoring data elements and screening tools for proactive and reactive suicide crisis care. For preventative care, VA uses predictive models to determine which Veterans may be at highest risk of suicide, so providers can intervene early. For those veterans in suicide crisis, the Veterans Crisis Line is available to veterans in time of need. The Veterans Crisis Line has answered over 2.3 million calls, 55,000 texts, and made over 376,000 referrals to a Suicide Prevention Coordinator.	**Mental Health Detection and Prevention** Epic builds in preventive care and screening for depression and suicide risk, as well as associated follow-up plans, in physician, nurse and clinician workflows to ensure high visibility amongst all team members. Veterans determined at risk for a crisis event after assessment can be automatically referred to a Suicide Prevention Coordinator without any additional end user intervention. For veterans in crisis, same-day mental health or telehealth appointment slots are reserved for their care. *Customer Success* • Institute of Family Health reached a depression screening rate of nearly 90% through workflows in Epic.
Mental Health	**Four Principles of VA Mental Health Care** Mental health is the most pervasive health issue the VA faces on a daily basis. 50% of all veterans face mental health issues, according to VA Secretary David Shulkin, with 30% of soldiers developing mental problems within 3 to 4 months of being home. VA has developed core principles as a foundation to improve veteran mental health, including a 1) A Focus on Recovery, 2) Coordinator Care for the Whole Person 3) Mental Health Treatment in Primary Care and 4) Providing Veterans with a Mental Health Treatment Coordinator.	**The Right Data at the Right Time** Epic support of mental health workflows ensures that whether a veteran has an acute or a chronic condition, clinicians have the tools keep the veteran healthy. Key lab, demographic and assessment data are combined in a single view for easy analysis and diagnosis. *Customer Success* • UCLA implemented veteran mental health program in partnership with Wounded Warriors for psychological health support • JPS saw use of evidence-based protocols on dosing, best practices, and pitfalls increase from 6% to 95% on their Virtual Psychiatric Service.
Drug and Opioid Addiction	**Managing the Epidemic** Though all of the United States struggles with managing the drug and opioid crisis, the VA has a disproportionate rate of drug and opioid issues compared to the civilian population. Over 50% of veterans deal with chronic pain, compared to 30% of Americans nationwide. Veteran opioid-use disorders spiked by 55% from 2010 to 2015, and veterans are twice as likely to die from accidental opioid overdoses as non-veterans. The VA provides effective, scientifically proven drug and opioid dependency services for all veterans, no matter where they come for services.	**Addiction Care Planning Tools** Integrated clinical and pharmacy data within Epic aids in the identification of veterans with drug addictive behavior. Opioid reporting tools built into the system allow organizations to monitor and track prescriptions. Health and history assessments drive risk scores within Epic that detect patients with possibility of drug addiction, and automatically flag them for support services. *Customer Success* • MetroHealth saved 500 lives with Opioid Overdose Prevention Program through risk scoring and care planning tools within Epic.

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Prostheses and Physical Therapy	**Rehab and Prosthetic Care** Over 31% (2.38 million) of all Veterans treated in VHA saw a rehabilitation care provider and nearly half of all Veterans seen in VHA have received prosthetic and sensory aids items and services. VA's Rehabilitation and Prosthetic Services office aligns medical expertise, clinical and practice guidance, and specialized procurement resources to provide comprehensive rehabilitation, prosthetic and orthotic, services across the VHA health care system in the most, economical and timely manner.	**Rehab for the Clinician and Veteran** All veteran information from an initial prosthetic placement or injury consults and subsequent physical therapy visits are grouped together under a single therapy episode for ease of data access. Patient Goals tools allow veterans to track and contribute to their progress without clinician intervention, such as recording minutes walked each day, via the MyChart. *Customer Success:* • Hospital For Special Surgery implemented scheduling acute care visits with Epic, enabling a systematic approach to care provisioning to ensure all patients are seen.
Women's Health	**Raising the Bar for Women Health Services** Women are the fastest growing veteran population and VA strives to be a national leader in the provision of health care for women. However, there are still barriers to women veteran care today, such as effective outreach addressing women's health, location and hours of women's services, and gender sensitivity of health care staff. The Women Veterans Health Care program aims to break down these barriers to ensure that timely, equitable, comprehensive and high-quality health care is provided in a sensitive and safe environment at VA facilities nationwide.	**Increase in Positive Health Outcomes for Women** Epic creates standard ways to document medical histories for gender minorities, preventing clinically relevant information from being overlooked and helping clinicians provide tailored care. Epic's pregnancy tools include prenatal checklists to ensure that prenatal checkups and education classes are completed. *Customer Success:* • UPMC increased prevention of medication-induced births by notifying physicians when they order teratogenic medications for women who could become pregnant. • Children's Hospital Colorado saw clinicians act on 99% of decision support reminders to screen mothers for postpartum depressions.
Veteran Housing and Food Insecurity	**Supporting the Homeless and Hungry** Veteran care delivery goes beyond the walls of the traditional care setting. VA is serving more Veterans than ever who are homeless or at risk of homelessness. Since 2010, more than 365,000 Veterans and their family members have been permanently housed or prevented from falling into homelessness. In recent years, hunger among the more than 12 million veterans over 60 is reaching critical levels, and estimates are that over 300,000 elderly veterans are food insecure. Efforts at VA to keep veterans fed and with shelter prevent more serious health events.	**Epic in the Community** Epic uses social determinants of health to flag veterans who may be at risk for food and shelter needs to automatically enroll them in social programs. Healthy Planet Link provides web based tools to community organizations to contribute health and social assessments into the patient chart. *Customer Success* • ProMedica implemented a screening initiative to connect patients experiencing hunger or food insecurity to an on-site food pharmacy and other food resources. • OHSU utilized Epic to identify patients for a transitional care program, helping to improve quality of care for the underserved who transition from the hospital to home.

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Veteran Access to Care	**Right Access at the Right Time** Provide timely access to veterans as determined by their clinical needs is the number 1 priority at VA. VA has initiated a number of programs to make sure veterans receive the care they very much so deserve. The partnership between the VA and CVS in California now offers urgent care services to more than 65,000 veterans. The Stand Down initiative ensured 56,000-plus identified urgent care had been successfully resolved. Additional healthcare staff and an increase in advanced scheduling software has helped decrease veteran wait times.	**Faster Access to Care with Scheduling Tools** Referrals provide closed-loop communication in Epic allowing staff at VA to verify that a veteran received care at an outside facility, such as CVS or Walgreens. Epic's Fast Pass automated wait list tool lets veterans receive earlier appointment slots as they open up due to cancellations. Most critical patients, such as those with mental health and life threatening illnesses, are offered earlier appointments first. *Customer Success* • Kaiser Permanente saw a 50% reduction in no show appointment rates for patients who booked online using MyChart.
Team Based Approach to Care	**Coordination Across Care Team Members** A core strength at VA is its team-based, Veteran-centric model of primary care that focuses on patient-driven, proactive, and personalized care. This patient aligned care team — including primary care providers, nurses, social workers, pharmacists, nutritionists, behavioral health professionals, as well as the Veteran, family members, and caregivers — addresses not only disease management, but also disease prevention, wellness, and health promotion.	**Communication is Key** Epic focuses on providing patient care via a multi-disciplinary approach. Treatment planning tools, screenings and risk scores, are embedded throughout all clinical workflows. Clinicians utilize a longitudinal plan of care that summarizes data across all encounters. Secure Chat allows care team members to send secure text messages through desktop and mobile devices. *Customer Success:* • Bronson developed a multidisciplinary medication reconciliation program to decrease readmissions, reduce case manager workload, and improve clarity of patient medication instructions
Dispersed Patient Population	**Access to Care Anywhere** A quarter of all Veterans in US, 5.2 million, returned from active military careers to reside in rural communities, Even with VA's large footprint across the nation, veterans may often find themselves hours from the nearest VA healthcare facility, or out of reach of specialist that they can regularly see due to living in a remote or rural area. The Office of Rural Health provides enterprise-wide programs to veterans in rural areas to make sure they stay healthy. Programs include Tele-Intensive Care Units, Telemental Health Hubs, Rural Health Social workers, Rural Transportation Service, and Remote, telephone-based delivery of cardiac rehabilitation.	**See Your Patients Sooner** Home Health tools in Epic allow home care nursing staff to stay connected. Traveling staff can communicate back to a full clinician care team while out in the field with a veteran via real time video and documentation needs. Telemonitoring tools expand veteran access to specialists regardless of where they are located. *Customer Successes* • Mercy Health's Telehealth program reduced inpatient length of stay and mortality rates declined by 40 percent, while the average cost of care significantly declined as fewer patients require a hospital stay. • Telestroke tools and workflows in Epic allow neurologists to diagnose and treat a patient exhibiting stroke symptoms at a different location using a video feed.

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Veteran Care Coordination with DoD and Private Sector	**Facilitating Data Exchange** The majority of veterans use non-VA health care providers in addition to their VA providers. The VA has been a pioneer in healthcare IT to help connect veteran healthcare with data from both DoD private sector. VA has been a partner of eHealth Exchange, a network that connects federal agencies (including the VA, DoD, and SSA) and nonfederal organizations to improve patient care, streamline disability benefit claims, and improve public health reporting through interoperable health information exchange. VA has enhanced coordination in recent years with DoD through implementation of the Joint Legacy Viewer (JLV), a read-only tool that lets VA and DoD clinician see data from each system.	**Most Experienced in Interoperability** 100% of Epic organizations are interoperable with organizations inside or outside of the Epic community. Epic is a proud member of the eHealth Exchange, as well as Carequality, a public-private, multi-stakeholder collaborative that uses a consensus-based process to enable seamless connectivity across all participating networks. Cerner/commonwell, athenahealth, eClinicalWorks, NEXTGEN, GE and surescripts are all carequality participants. • 90 billion transactions occur between Epic systems and non-Epic systems each year. • Epic's Care Everywhere is the #1 ranked Health Information Exchange (HIE). • No other EHR vendor has enabled 100% of its healthcare organizations to interoperate.
Research	**Facilitating Research Efforts** VA Research and Development plays a key role in advancing the health and care of Veterans, engaging patients and family's altruistic desires to improve health for fellow Veterans and others. VA fosters dynamic collaborations both within VHA and with external partners, such as the National Institutes of Health, academic affiliates and community partners. Research efforts in the VA such as the Million Veteran Program (MV), the largest genomic database in the world, aim to partner with Veterans receiving their care in the VA Healthcare System to study how genes affect health. The VA research partnership with IBM uses Watson to help VA doctors tailor cancer care. In 2016, VA spent $1.8 billion on research.	**Reduce Barriers to Clinical Research** Epic's research module natively integrates clinical workflows and documentation with clinical trials and observational studies to help advance communication and partnership between clinicians and researchers. The Cosmos Research Network, Epic's cross-organization research collaboration, will allow participants access a database to compare therapies and outcomes, discover causes, identify side effects, determine efficacy of treatments, and study extreme outliers through a nationwide patient dataset. *Customer Statistics* • The Top 15 NIH research grants by amount of funding go to organizations that use Epic. • 14 of 15 U.S. News and World Report's top medical research hospitals use Epic. • The Flint, Michigan water study used Epic to discover the lead crisis at hand.
Largest Safety Net in the U.S.	**Serving the Underserved** The VA shares many of the same characteristics of large safety nets, and the VA could be considered the largest of all safety nets in the US. Health issues such as diabetes, domestic abuse, and obesity are disproportionality high within the veteran population. VA responds to the needs of the socially-disenfranchised with targeted programs, outreach, and prevention.	**More Safety Net Organization Use Epic** Epic is the chosen software vendor for many of the nation's largest safety net organizations such as Contra Costa, Legacy Health, MetroHealth, and New York City Health and Hospitals. *Customer Success* • Legacy Health uses Community Connect for disability group homes. • Contra Costa uses Epic in detention centers.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/27/2017 11:09:52 AM
To: David shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: VA mental Heath

Sent from my iPad
Bruce Moskowitz M.D.

Begin forwarded message:

From: (b) (6) <(b) (6) nyspi.columbia.edu>
Date: April 26, 2017 at 11:22:47 PM EDT
To: Bruce Moskowitz <(b) (6) mac.com>
Subject: Re: VA mental Heath

Bruce let me know if you need the statement endorsing McCance-Katz nomination sent as a letter on my letter-head

(b) (6) M.D.

Lawrence C. Kolb Professor and Chairman of Psychiatry,

Columbia University College of Physicians and Surgeons,

Director, New York State Psychiatric Institute

Psychiatrist-in-Chief,

New York Presbyterian Hospital-Columbia University Medical Center

1051 Riverside Drive - Unit #4

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www.(b) (6) com

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Follow me on twitter @[redacted]

Find me on facebook

Watch my talk on TEDx

Watch my talk on NATCON CONFERENCE

From: [redacted] <[redacted]nyspi.columbia.edu>
Date: Wednesday, April 26, 2017 at 4:32 PM
To: Bruce Moskowitz <[redacted]mac.com>
Subject: Re: VA mental Heath

Bruce, see comments re our discussion on the Asst Secy appointment, recommendations to Secy Shulkin on military mental health and research. Sorry for the length. Let me know if you need me to send in different format. [redacted]

1. <!--[if !supportLists]--><!--[endif]-->**Assistant Secretary of Mental Health**

I enthusiastically support (as does the APA https://www.psychiatry.org/newsroom/news-releases/apa-supports-nomination-of-dr-mccance-katz-urges-senate-to-confirm) Dr. Elinore McCance-Katz for the Asst Secy position. She is an M.D., Ph.D. with a background in addiction research and clinical care, who is committed to and experienced in public mental health care. She moved from the Univ. of California at San Francisco where she was on the faculty in the Dept of Psychiatry, to become Medical Director of SAMHSA. After only a year she resigned from this position because she appropriately objected to the unscientific and wasteful activities of the agency and its hostility to modern medicine and evidence based mental health care. Most recently, she was the Director of Mental Health for the State of Rhode Island. She is qualified and would be an excellent choice, despite what Congressman Murphy has said.

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2. <!--[if !supportLists]--><!--[endif]-->**Improving Military Mental Health Care**

The first *attachment* is a summary providing guidance to the Secretary of the Veterans Administration on how to improve mental health care to military personnel. Briefly, what I recommend to Secretary Shulkin is:

1. Convene a review committee of experts in mental health care, services, systems and financing.
2. Committee to review existing scope of VA programs and services to identify which work and are good (or could be with better staffing and oversight) and what new services need to be developed.
3. Develop a plan for implementation including resource, workforce, training and quality control and oversight.

3. <!--[if !supportLists]--><!--[endif]-->Disruptive Research

I believe that if funding is directed to the best scientists to carry out goal directed research on the most urgent military mental health, game-changing progress can be made in PTSD, suicide, aggression and TBI. Three examples of outstanding research proposals by National Academy of Science level researchers that have never worked on military or VA issues and have been denied funding are summarized below.

1. **Development of Stress Resilience–Enhancing Medications as Primary Prophylaxis against PTSD and MDD**

Christine Denny, Ph.D. and Rene Hen, Ph.D.

Columbia University

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Post-traumatic stress disorder (PTSD) is a leading mental health problem that can occur after a traumatic event,

such as sexual assault, war, or injury. PTSD affects approximately 8 million adult Americans, with an annual

prevalence of 3.5% across the general population (Kessler et al., 2005). Soldiers and veterans, however, are at

greater risk of developing PTSD. The estimated prevalence of PTSD is 13.8% in previously deployed Operation

Enduring Freedom and Operation Iraqi Freedom (Afghanistan and Iraq) service members, and 10.1% in Gulf

War Veterans, and lifetime prevalence, including partial PTSD, is over 30% in American Vietnam theater

veterans (Tanielian et al., 2008; Kang et al., 2003; National Vietnam Veterans Readjustment Study (NVVRS)).

Department of Defense (DoD) expenditure on PTSD care for service members has increased over time,

reaching almost $300 million in 2012. In the same year, the Veterans Affairs (VA) spent $3 billion on PTSD

care for veterans; a striking reminder of the chronic and cumulative costs of the disease (IOM, 2014). In

addition to PTSD, depression affects 350 million people worldwide and has now surpassed HIV/AIDS, malaria,

diabetes, and war as the leading cause of disability (Marcus et al., 2016). Estimated at $2.5 trillion in 2010, the

global cost of mental illness is expected to rise to $6 trillion in the next 15 years (Bloom et al., 2011).

Furthermore, rates of depression are five times higher in soldiers than in civilians (The Army Study to Assess

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Risk and Resilience in Servicemembers (Army STARRS)).

Stress exposure is one of the greatest risk factors for both major depressive disorder (MDD) and PTSD.

Traumatic life stress causes PTSD and is the initial trigger in 80% of cases of MDD (Mazure, 2006).

Traditionally, affective disorders have been treated from a symptom-suppression approach. Existing drugs aim

to mitigate the impact of these chronic diseases, but do not cure or prevent the disease itself. There are no

known cures. Prevention, if discussed at all, is usually thought of only in terms of behavioral interventions.

However, if drugs were developed that enhance stress resilience, they could potentially be used in at-risk

populations to protect against stress-induced psychiatric disorders.

Describe how the proposed research project addresses one or more of the FY16 PRMRP Topic Areas.

The proposed project is relevant to the FY16 PRMRP Topic Area of Psychotropic Medications. Specifically, our

research will directly address: 1) the FY16 PRMRP Area of Encouragement: research on the use of

psychotropic medications to increase resilience in military units. We have discovered the first resilienceenhancing

compounds that may prevent stress-related psychiatric disorders. This proposal aims to identify and

develop novel lead compounds with potential resilience-enhancing and prophylactic efficacy against these

disorders. This proposal also addresses: 2) the FY16 PRMRP Area of Encouragement: research to evaluate the

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use of psychotropic medications for mental health issues specific to women in the military. All the experiments

that we have outlined will be performed in male and female mice. This is of the utmost importance as women

respond differently to medications and are twice as likely to develop MDD and PTSD.

The ultimate product to be developed is a psychotropic drug that enhances resilience and provides long-lasting protection against stress-induced psychiatric disorders, like PTSD and MDD, in a prophylactic (or

vaccine-like) fashion. Using targeted compound screening and subsequent hit-to-lead optimization followed by lead optimization, this proposal aims to develop a suitable clinical candidate for a subsequent

Investigational New Drug (IND) application.

Stress resilience: One in five soldiers returns from combat with PTSD, combat-associated MDD, or both

(Tanielian et al., 2008). Perhaps more surprising, however, is that 4 out of 5 soldiers do not develop

psychopathology. This ability to adapt to stress without developing psychopathology is known as

stress resilience. Until recently, research on stress resilience has been predicated on the assumption that resilience is a passive property – more or less the absence of the risk factors that make individuals

susceptible to stress-induced pathology. Recent work in animal models, however, suggests that the

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neurobiology of stress resilience is mediated through active processes, and often distinct, parallel

mechanisms to those of susceptibility (Krishnan et al., 2007; Chaudhury et al., 2013; Walsh et al., 2014).

The idea that enhancing stress resilience could protect against the development of psychiatric disorders

is an appealing one, but treatments to increase resilience are still in their infancy. Current interventions fall

predominantly on the behavioral side, with psychotherapy, exercise, and stress inoculation—mild stress

exposure to promote adaptive coping to subsequent severe stress (Levine, 1957; Lyons and Parker, 2007)—

being the best available tools to increase resilience clinically (Meredith et al., 2011). Rodent studies also

suggest a role for exercise and enriched environment in stress resilience (Schloesser et al., 2010; Lehmann and

Herkenham, 2011; Schoenfeld, et al., 2013). Beyond behavioral manipulations, researchers have successfully

increased resilience biochemically in mice through viral and transgenic overexpression methods (Donahue et

al., 2014), optogenetic activation (Chaudhury et al., 2013), and chronic blockade of stress hormones. However,

none of these interventions is directly translatable to the clinic. Here, we propose to develop the first clinically

applicable resilience-enhancing therapeutics for the prevention of stress-induced psychopathology.

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2. A Clinical Trial of Letrozole for the Treatment of Irritable Aggression in PTSD

David Anderson, Ph.D.

California Institute of Technology

http://www.bbe.caltech.edu/content/david-j-anderson

Rationale: Both military trauma exposure and posttraumatic stress disorder (PTSD) have been linked to problems with aggression. Trauma-related irritable aggression is associated with impairments in interpersonal relationships, dysfunction at work and school, intimate partner violence, and legal problems. Among male combat veterans of the conflicts in Iraq and Afghanistan, 57% reported problems controlling anger, and controlling anger was the most common post-deployment readjustment problem reported by veterans with and without probable PTSD (Sayer et al, 2010). More serious manifestations of aggression affect a smaller yet substantial subpopulation: 13% of Iraq and Afghanistan veterans reported engaging in violence towards family, while 9% reported violence towards strangers. Violent criminal offenses were found to be 2-3 times higher (6-8%) in veterans with PTSD compared to those without PTSD (3%). Irritability, anger, and aggressive behavior are often targeted for treatment in patients with PTSD. While cognitive behavioral therapy (CBT) for PTSD modestly reduces anger symptoms, response rates are less than optimal, and several studies show an association between baseline anger and CBT non-response. Further, retention of veterans in CBT for aggression can be difficult, and those terminating early demonstrate no improvement (Galovski et al., 2014).

For patients unwilling to engage in CBT, or who do not respond optimally, a pharmacological option may be beneficial. However, there *are no established* pharmacological treatments with clear efficacy for irritable or impulsive aggression in PTSD. Specific effects on aggression of serotonin reuptake inhibitors (SSRIs), the only FDA approved medications for the treatment of PTSD, have not been investigated; in fact, increased irritability and anxiety are potential side effects of SSRIs.

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Moreover, male combat veterans are often resistant to SSRIs (e.g., Friedman et al., 2007), although ethnic differences may play a role. Although not well-investigated, anti-adrenergic medications (e.g., prazosin or doxazosin) and atypical neuroleptics may counter irritable, impulsive aggression in some veterans by antagonizing effects of stress-induced monoamine surges at noradrenergic alpha-1 or serotonin (5HT)-type 2 receptors in the frontal lobe or amygdala, or secondarily through effects on sleep (Pitman et al., 2012). These agents are often avoided, however, due to potential long-term side effects (e.g., tardive dyskinesia or metabolic syndrome) or undesirable drug interactions (alpha-1 noradrenergic antagonists interact unsafely with drugs for erectile dysfunction). It is therefore critical to develop new, well-tolerated, and more effective pharmacotherapeutics for irritable impulsive aggression in veterans.

A potential novel approach to reducing irritable aggression has arisen recently from work in rodents (Anderson, 2012, 2016). Evidence accumulated over the last 25 years indicates that conversion of testosterone (T) to estrogen (E) by the enzyme aromatase (AT) contributes to many physiological processes and behaviors in males, including aggression. In mutant mice lacking the androgen receptor, supplemental T restores male aggressive behavior. AT gene knockout reduces inter-male aggression, an effect reversed by E. AT inhibitors (AIs) reduce aggression in fish, birds and rodents; thus, effects on aggression of AT gene knockout are not due simply to developmental effects of reduced E. AT is expressed in brain regions implicated in aggression, including the hypothalamus, frontal cortex and amygdala. The laboratory of our collaborator, David Anderson, Ph.D., has recently shown that neurons in the ventromedial hypothalamus (VMH) that promote aggression in mice express the E-1/alpha receptor (Esr1) (Lee et al., 2014). Knockout of the *Esr1* gene dramatically reduces inter-male aggression in mice, an effect that cannot be overcome by T. Similarly, RNAi-mediated knock-down of Esr1 mRNA in the VMH dramatically reduces inter-male aggression (Sano et al., 2013).

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A shift away from E to T synthesis by AI administration, even though T and E levels may stay within the normal range (Goudrian et al., 2010), may also influence other neurobiological systems of relevance to PTSD. T increases, while E inhibits, synthesis of neuropeptide Y (NPY), which in turn modulates sympathetic system reactivity, anxiety, distress, and dissociation during stress. Baseline NPY levels and NPY responses to sympathetic system activation are markedly low in combat veterans with PTSD. In contrast, increased NPY responses to extreme stress correlate positively with military performance requiring *behavioral restraint* and *use of previously learned skills*. E also upregulates $5HT_{2A}$ receptors in the frontal cortex of males and females (e.g., Frokjaer et al., 2010). Increases in frontal cortical $5HT_{2A}$ receptors have been observed in post-mortem brain of violent suicide victims (Mann et al, 1989; Hrdina et al., 1993), and by neuroimaging in the brains of impulsively aggressive dogs (Vermeire et al., 2011) and humans (Laruelle et al., 2010; Rosell et al., 2010). T also upregulates allopregnanolone in males (Mitev et al., 2003), whereas experimentally induced allopregnanolone deficits result in mouse-on-mouse homicidal aggression (Pinna et al., 2005). An estrogen-$5HT_{2A\ or\ 2C}$ receptor-aggression endophenotype is supported in the PTSD literature. Southwick et al. (1997) demonstrated that one third of Vietnam veterans with PTSD experienced acute panic and PTSD symptoms in response to meta-chlorophenylpiperazine (mCPP), a potent $5HT_{2A,}$ $5HT_{2B,}$ and $5HT_{2c}$ receptor agonist. It thus should come as no surprise that a loss-of-function allele of the serotonin transporter gene that increases synaptic 5HT levels increases PTSD risk, or that SSRIs are ineffective in so many male veterans. Whether this endophenotype manifests in women is less clear; however, a polymorphism of the E-sensitive PACAP gene increase PTSD risk in women. These studies thus suggest that reducing T to E conversion by AIs may reduce irritable aggression as well as other symptoms of PTSD.

Data so far support the safety of AIs in men (Goudriaan et al., 2010; de Ronde and de Jong, 2011). AIs are prescribed in males for a variety of medical disorders, including infertility, short stature, and gynecomastia. They also are used by body builders to counter the negative impact of exogenous T. AIs used widely for breast cancer chemoprevention in women are associated with modest decreases in bone mineral density.

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However, AIs appear to have less impact on bone in males, possibly because of the high rate of T to E conversion in males. A 10-week course of anastrozole in young eugonadal males revealed no catabolic effects on protein metabolism, body composition, muscle strength, or bone calcium metabolism. Also, no significant side effects or negative effects on metabolism were observed in a 10-day trial of exemestane in males.

3. Role of Leaky Neuronal Ryanodine Receptors in Stress-Induced Cognitive Dysfunction

Andrew R. Marks M.D., Ph.D.

Department of Physiology and Cellular Biophysics, Clyde and Helen Wu Center for Molecular Cardiology

Columbia University College of Physicians and Surgeons

SUMMARY

The type 2 ryanodine receptor/calcium release channel (RyR2), required for excitation-contraction

coupling in the heart, is abundant in the brain. Chronic stress induces catecholamine biosynthesis

and release, stimulating b-adrenergic receptors and activating cAMP signaling pathways in neurons.

In a murine chronic restraint stress model, neuronal RyR2 were phosphorylated by protein kinase A(PKA),

oxidized, and nitrosylated, resulting in depletion of the stabilizing subunit calstabin2 (FKBP12.6)

from the channel complex and intracellular calcium leak. Stress-induced cognitive dysfunction, including

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deficits in learning and memory, and reduced long-term potentiation (LTP) at the hippocampal

CA3-CA1 connection were rescued by oral administration of S107, a compound developed in our laboratory

that stabilizes RyR2-calstabin2 interaction, or by genetic ablation of the RyR2 PKA phosphorylation

site at serine 2808. Thus, neuronal RyR2 remodeling contributes to stress-induced cognitive dysfunction.

Leaky RyR2 could be a therapeutic target for treatment of stress-induced cognitive dysfunction.

(b) (6) M.D.

Lawrence C. Kolb Professor and Chairman of Psychiatry,

Columbia University College of Physicians and Surgeons,

Director, New York State Psychiatric Institute

Psychiatrist-in-Chief,

New York Presbyterian Hospital-Columbia University Medical Center

1051 Riverside Drive - Unit #4

New York, NY, 10032

Phone (646) 774-(b) (6)

email: (b) (6) columbia.edu

www.(b) (6) com

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Follow me on twitter @[redacted]

Find me on facebook

Watch my talk on TEDx

Watch my talk on NATCON CONFERENCE

From: Bruce Moskowitz <[redacted]mac.com>
Date: Friday, April 21, 2017 at 6:48 AM
To: [redacted] <[redacted]nyspi.columbia.edu>
Subject: Re: VA mental Heath

Anytime this weekend or next week

Sent from my iPad

Bruce Moskowitz M.D.

On Apr 21, 2017, at 2:51 AM, [redacted] <[redacted]nyspi.columbia.edu> wrote:

> Hi Bruce,
>
> Hope all is well. I have been involved with DS re VA mental health and that interaction has gone well. Thank you for facilitating. I would like to briefly chat with you re couple of related issues. Please let me know when would be a convenient time to call you or best way to arrange.
>
> [redacted]
>
> [redacted] M.D.
>
> Lawrence C. Kolb Professor and Chairman of Psychiatry,

AMERICAN OVERSIGHT

Columbia University College of Physicians and Surgeons,

Director, New York State Psychiatric Institute

Psychiatrist-in-Chief,

New York Presbyterian Hospital-Columbia University Medical Center

1051 Riverside Drive - Unit #4

New York, NY, 10032

Phone (646) 774-[redacted]

email: [redacted]columbia.edu

www.[redacted]com

Follow me on <image001.png> @[redacted]

Find me on <image002.png>

Watch my talk on <image003.png>

Watch my talk on <image004.png>

From: Bruce Moskowitz <[redacted]mac.com>
Date: Tuesday, March 14, 2017 at 7:25 PM
To: [redacted] <[redacted]nyspi.columbia.edu>
Cc: David Shulkin <drshulkin@aol.com>
Subject: VA mental Heath

Thank you David and I will review.

Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/11/2017 11:13:09 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: USH commission

No

Sent from my iPhone

> On Apr 11, 2017, at 5:34 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Is Bruce on it
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/11/2017 9:34:59 AM
To: David Shulkin [drshulkin@aol.com]
Subject: USH commission

Is Bruce on it

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/12/2017 11:37:11 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Thanks for this tremendous opportunity

I cannot imagine a bigger platform for us to be doing together at this time- and then after this experience we can do something amazing as well

Sent from my iPhone

> On Apr 12, 2017, at 5:53 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> I am so emotional and probably am overreacting today, but I know you understand.
>
> In this moment, I truly and sincerely believe that it is because of you, David, that I have had a very very small role in a huge opportunity to make a positive impact on the care of my veterans. I just want to ingrain this moment in my memory forever. After all, this is the purpose of life- to make a positive impact in the lives of others- and you are helping me with my purpose! I don't know how long we will be working together and if there are other things we will accomplish together, but it has all been worth it my dearest friend! Thank you!
>
> Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/12/2017 9:53:06 AM
To: Drshulkin@aol.com
Subject: Thanks for this tremendous opportunity

I am so emotional and probably am overreacting today, but I know you understand.

In this moment, I truly and sincerely believe that it is because of you, David, that I have had a very very small role in a huge opportunity to make a positive impact on the care of my veterans. I just want to ingrain this moment in my memory forever. After all, this is the purpose of life- to make a positive impact in the lives of others- and you are helping me with my purpose! I don't know how long we will be working together and if there are other things we will accomplish together, but it has all been worth it my dearest friend! Thank you!

Sent from my iPad

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/9/2017 2:09:31 PM
To: (b) (6) [redacted]@gmail.com
Subject: Re: MITRE

ok that's fine- I have had no further discussions

-----Original Message-----
From: Darin Selnick <(b) (6) [redacted]@gmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sun, Apr 9, 2017 9:42 am
Subject: MITRE

Did MITRE get back with you after they met with Baligh and me? Baligh and I had agreed the time to engage them would be after we had solidified the future vision, which we did on Friday.

I think we are ready, and I recommend we bring MITRE or some one to help us use the systems approach to flush out and develop our fully developed roadmap starting with an impact vs. feasibility assessment. This would be accomplished at the same time we are working with Congress on legislation and with stakeholders. We really need this to finalize the legislation so that it is air tight.

I recommend we start this process next week.

Darin

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Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/9/2017 1:42:18 PM
To: David shulkin [Drshulkin@aol.com]
Subject: MITRE

Did MITRE get back with you after they met with Baligh and me? Baligh and I had agreed the time to engage them would be after we had solidified the future vision, which we did on Friday.

I think we are ready, and I recommend we bring MITRE or some one to help us use the systems approach to flush out and develop our fully developed roadmap starting with an impact vs. feasibility assessment. This would be accomplished at the same time we are working with Congress on legislation and with stakeholders. We really need this to finalize the legislation so that it is air tight.

I recommend we start this process next week.

Darin

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/14/2017 1:07:03 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: In the full report

Just missing someone

Sent from my iPad

On Apr 13, 2017, at 9:05 PM, David shulkin <Drshulkin@aol.com> wrote:

> I never saw a one word Poonam reply
>
> Must have been a tough day!
>
> Sent from my iPhone
>
> On Apr 13, 2017, at 8:53 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Thanks
> >
> > Sent from my iPhone
> >
> > On Apr 13, 2017, at 6:26 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
> >
> > <IMG_0063.PNG>
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/14/2017 1:05:06 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: In the full report

I never saw a one word Poonam reply

Must have been a tough day!

Sent from my iPhone

On Apr 13, 2017, at 8:53 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Thanks
>
> Sent from my iPhone
>
> On Apr 13, 2017, at 6:26 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> <IMG_0063.PNG>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/14/2017 12:53:52 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David shulkin [drshulkin@aol.com]
Subject: Re: In the full report

Thanks

Sent from my iPhone

On Apr 13, 2017, at 6:26 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:

<IMG_0063.PNG>

Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: IP [(b) (6) frenchangel59.com]
Sent: 4/12/2017 2:35:24 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: (b) (6) of Kaiser Permanente - #2 Powerful man in the healthcare

FYI

From: (b) (6) EOP/WHO [mailto(b) (6) who.eop.gov]
Sent: Wednesday, April 12, 2017 10:31 AM
To: IP
Cc: (b) (6) EOP/WHO
Subject: Re: (b) (6) of Kaiser Permanente - #2 Powerful man in the healthcare

Thanks

Sent from my iPhone

On Apr 12, 2017, at 10:29 AM, IP <(b) (6) frenchangel59.com> wrote:

> Please look at the links below before our call on (b) (6) This will help you understand what's possible.
>
> https://share.kaiserpermanente.org/article/chairman-ceo-bernard-j-tyson-kaiser-permanente-named-no-2-modern-healthcare-list-influential-health-care-leaders/
>
> https://www.bloomberg.com/graphics/2015-how-did-i-get-here/bernard-tyson.html

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Message

From: (b) (6) [(b) (6) gmail.com]
Sent: 4/12/2017 12:18:10 AM
To: David Shulkin [drshulkin@aol.com]; Vivieca Simpson [(b) (6) gmail.com]
Subject: Hires

http://www.politico.com/story/2017/04/donald-trump-white-house-staff-vacancies-237081

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 5/3/2017 2:30:32 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: (b) (6) [(b) (6) (b) (6) @uphs.upenn.edu]; drshulkin@aol.com
Subject: Re: TinnitusMalingeringTest-bwo1.docx

Is there an attachment you can send (b) (6) thanks

Sent from my iPhone

On May 2, 2017, at 1:19 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> Thank you
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> On May 2, 2017, at 1:13 PM, (b) (6) <(b) (6) (b) (6) @uphs.upenn.edu> wrote:
>
> > Bruce,
> > Please see the short summary that describes our development (in progress) of a test to see if a patient is "faking tinnitus". This is different from our parallel efforts ongoing that are focused on developing a test to confirm and potentially quantify tinnitus. This distinction is important as while we can wean out people who are faking with this concept I'm attaching in this email, we would need the other testing to substantiate the claim and extent of tinnitus that I mentioned in the previous emails and summaries.
> > (b) (6)
> >
> > (b) (6) (b) (6) M.D.
> > Gabriel Tucker Professor and Chairman
> > Dept of Otorhinolaryngology - Head and Neck Surgery
> > Associate Vice President, Director Physician Network Development
> > The University of Pennsylvania Health System
> >
> > 3400 Spruce Street - 5 Ravdin
> > Philadelphia, PA 19104
> > 215-349-(b) (6) (Academic Office)
> > 215-615-(b) (6) (Clinical Office)
> > 215-615-(b) (6) (Fax)
> >
> > <TinnitusMalingeringTest-bwo1.docx>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/12/2017 7:30:32 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Fwd: ugh

Sent from my iPhone

Begin forwarded message:

> **From:** "Slack, Donovan" <dslack@usatoday.com>
> **Date:** April 12, 2017 at 3:11:55 PM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: ugh**
>
> This is a big problem and growing (thousands and thousands of readers in the past hour alone). Maybe consider instituting some kind of rapid response protocol for press and medical issues in future? Not sure that's even possible in a federal agency, but throwing it out there.
>
> https://www.usatoday.com/story/news/politics/2017/04/12/veterans-danger-va-hospital-washington-dc-investigation-finds/100376124/
> "A spokesman for the VA did not immediately respond to a message seeking comment."
>
> _____
> Donovan Slack
> White House and Veterans Affairs Correspondent
> USA TODAY
> (703) 854-8926 office
> (202) 415-9493 cell
>
> -----Original Message-----
> From: David shulkin [mailto:Drshulkin@aol.com]
> Sent: Wednesday, April 12, 2017 7:19 AM
> To: Slack, Donovan <dslack@usatoday.com>
> Subject:
>
> Donovan- thanks for another fair and accurate story - i truly appreciate how you do things
>
> David Shulkin
>
> Sent from my iPhone

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/15/2017 6:16:07 PM
To: (b) (6) hotmail.com; vacodjs1@va.gov
Subject: Events DC

(b) (6) we need a statement to be developed for release on Monday as to the facts and timelines of the events at DC. We should develop the statement and then we can decide if we want to release and if so what if any of this is appropriate for release.

As far as I Understand here is the timeline (VHA please confirm this as factual)- I am trying to focus on the major events and not all of the facts:

The conversion of logistics systems back from the new system back to the old system at DC VA occurred on January 9th.

On 1/12/17 the VISN requests VHA logistics to conduct an audit of the conversion.

An audit occurs on January 24th-26th and determined there are deficiencies

In February- the VISN and VHA logistics teams were notified and the Facility CLO was detailed off the service and an AIB was begun. A new Facility CLO was brought in and an action plan was sent to the VISN.

Assistance from the logistics team rom the VISN continues in March

At the end of March the VISN CMO rounds at the facility and identifies issues

DUSHOM sends memo with new actions on 3/21/17. In this memo it notes that the VISN contacted IG and asks for guidance

The VHA Patient Safety team came for a site visit on 3/22/17

IG arrives for a site visit on 3/29

IG contacts the PDSUSH on 3/30/17

On 3/30/17 a 12 person tiger team arrives to assist from Martinsburg VA

An ICC is stood up in April to oversee the efforts. Rounding on units occurs 2X per day.

IG shares interim report with Secretary on 4/12/17

Medical Center Director, Associate Director removed on 4/12/17

Acting Director Larry Connell Appointed on 4/12/17

USH arrives on site for personal oversight of ICC on 4/13/17

Full investigation of events being undertaken in cooperation with IG
At this point in the investigation there is no evidence of harm to any patient
Notification of the issues to the Secretary and USH did not occur prior to the IG interim report.

VHA conducting an assessment of inventory systems across VHA.

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/11/2017 8:32:59 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Today

I will have the team check in the meantime

Sent from my iPhone

On Apr 10, 2017, at 6:22 PM, David shulkin <Drshulkin@aol.com> wrote:

> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Slack, Donovan" <dslack@usatoday.com>
> > **Date:** April 10, 2017 at 3:35:48 PM EDT
> > **To:** David shulkin <Drshulkin@aol.com>
> > **Subject: Re: Today**
> >
> > Ha! No worries. James hand delivered the results page to me. I still have some concerns - 8 days sounds awfully short. But we'll see I guess if data measures up when site goes public.
> >
> > ---
> > Donovan Slack
> > White House and Veterans Affairs Correspondent
> > USA TODAY
> > dslack@usatoday.com
> > (703) 854-8926 Office
> > (202) 415-9493 Cell
> >
> > > On Apr 10, 2017, at 2:22 PM, David shulkin <Drshulkin@aol.com> wrote:
> > >
> > > Donovan- apparently i had not refreshed the computer as I should have - but now I see new mental health patients at the Phoenix VA is 8 days. Sorry about that- but as you can see I didn't rehearse this
> > >
> > > David
> > >
> > > [cid:ae64df80-24b4-4c48-b0eb-1aed4a330e2a@prod.exchangelabs.com]

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Sent from my iPhone

<IMG_3848.JPG>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/10/2017 10:21:32 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Today

Sent from my iPhone

Begin forwarded message:

> **From:** "Slack, Donovan" <dslack@usatoday.com>
> **Date:** April 10, 2017 at 3:35:48 PM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Today**
>
> Ha! No worries. James hand delivered the results page to me. I still have some concerns - 8 days sounds awfully short. But we'll see I guess if data measures up when site goes public.
>
> ---
> Donovan Slack
> White House and Veterans Affairs Correspondent
> USA TODAY
> dslack@usatoday.com
> (703) 854-8926 Office
> (202) 415-9493 Cell
>
> > On Apr 10, 2017, at 2:22 PM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > Donovan- apparently i had not refreshed the computer as I should have - but now I see new mental health patients at the Phoenix VA is 8 days. Sorry about that- but as you can see I didn't rehearse this
> >
> > David
> >
> > [cid:ae64df80-24b4-4c48-b0eb-1aed4a330e2a@prod.exchangelabs.com]
> >
> > Sent from my iPhone
> > <IMG_3848.JPG>

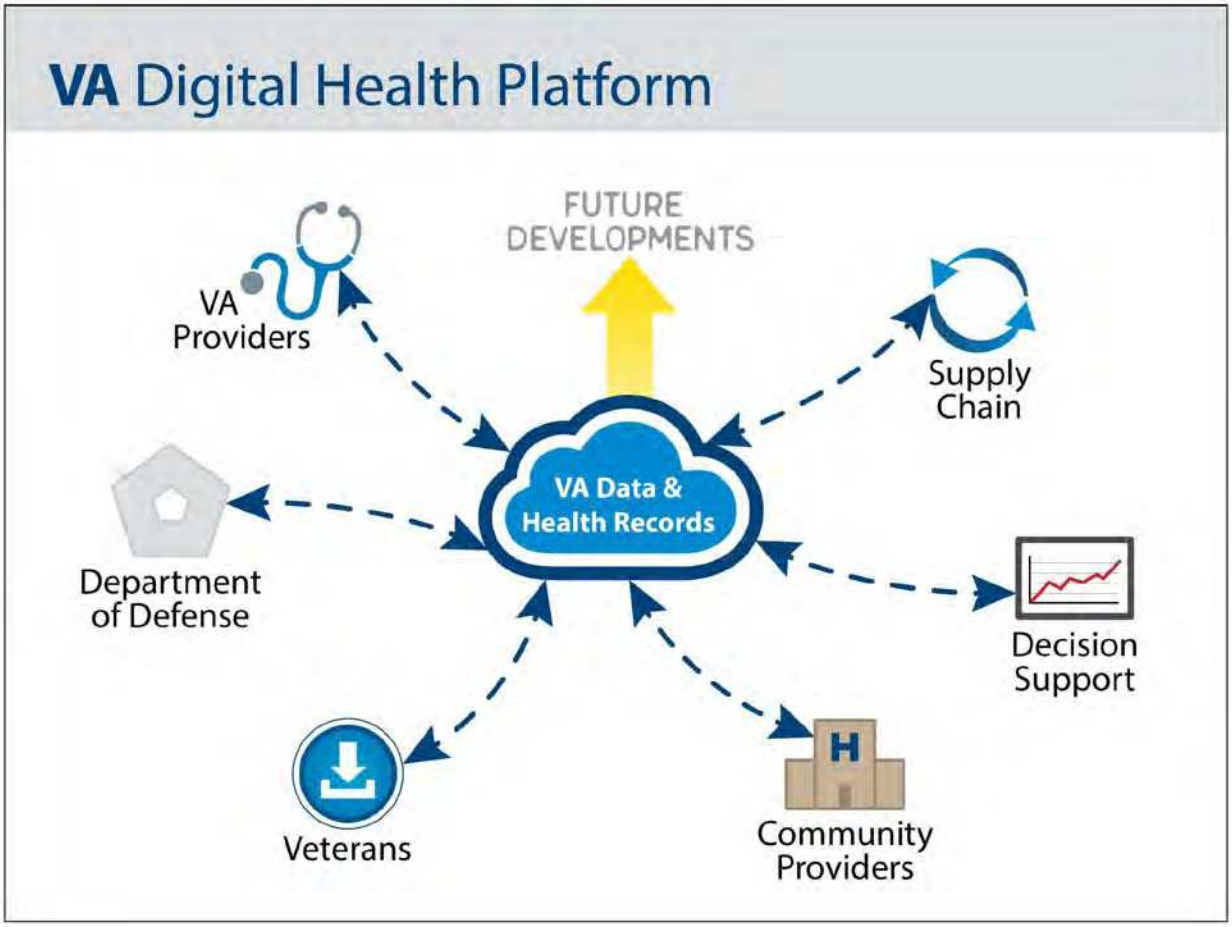
AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/13/2017 6:11:51 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Graphics slides
Attachments: DHP_diagram.pptx; Top5_Priorities_0417.pptx; Top5Priorities_04112017.pptx; Access_Accountability_slides.pptx

so you have for future use.

AMERICAN OVERSIGHT



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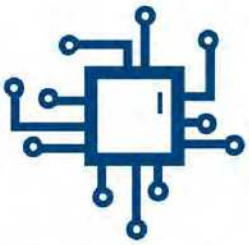
Top 5 Priorities for VA



Greater Choice



Modernize Systems



Focus Resources



Improve Timeliness



Suicide Prevention

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Greater Choice for Veterans

- Redesign the 40/30 Rule
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Modernize Our Systems

- Infrastructure improvements and streamlining services
- EMR interoperability and IT modernization

VA | U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability and effective management practices

VA | U.S. Department of Veterans Affairs

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Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

VA | U.S. Department of Veterans Affairs

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Suicide Prevention

- Getting to ZERO

VA | U.S. Department of Veterans Affairs

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VA | U.S. Department of Veterans Affairs

Top 5 Priorities

U.S. Department of Veterans Affairs

1. Greater Choice for Veterans

- Redesign the 40/30 rule
- Build a high-performing, integrated network of care
- Empower Veterans through transparency of information

2. Modernize Our Systems

- Infrastructure improvements and streamlining services
- EMR interoperability & IT modernization

3. Focus Resources More Efficiently

- Strengthening of foundational services in VA
- VA/DOD/Community coordination
- Deliver on accountability & effective management practices

4. Improve Timeliness of Services

- Access to care and wait times
- Decisions on appeals
- Performance on disability claims

5. Suicide Prevention

- Getting to zero

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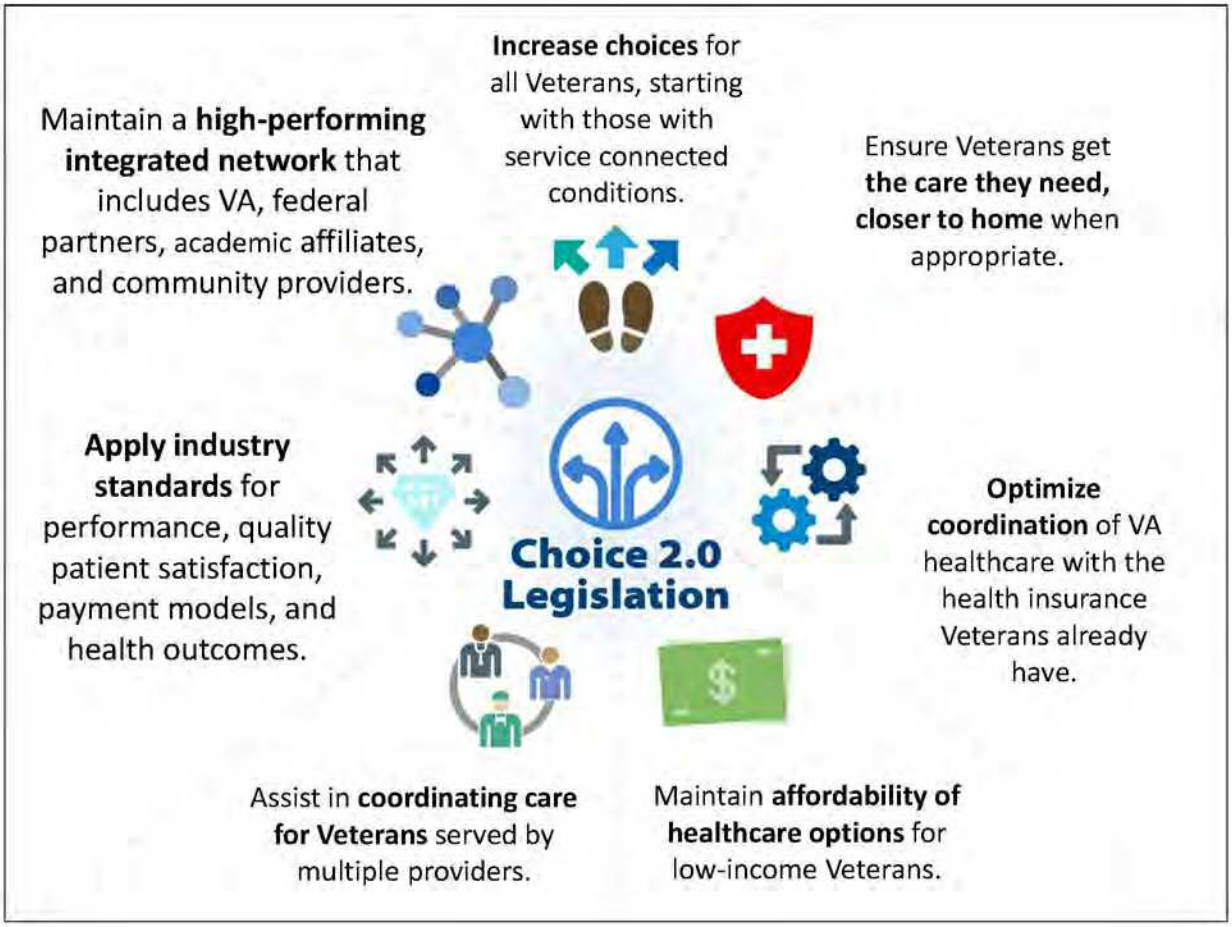
VA-19-0799-D-000868

DS_00002539



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Priority #4 **Accountability Legislation**

				
Increased **flexibility to remove, demote, or suspend** VA employees for poor performance or misconduct.	Authority to **recoup bonuses** of employees for poor performance or misconduct.	Authority to **recoup relocation expenses** authorized through fraud or malfeasance.	Authority to **reduce federal pensions** for employees convicted of felonies.	Increased **protections for whistleblowers**.

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/12/2017 10:33:45 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Jennifer's position

I am leaning towards Mike Valentino- he has a good track record of success, has a non controversial personality, should be accepted by both the field and 10P- what do you think

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/17/2017 6:34:28 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Project Healthy Heroes update
Attachments: HH Project Update_2017_04_17.pptx; Untitled attachment 05290.htm

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) [JSGUS]" <(b) (6) its.jnj.com>
Date: April 17, 2017 at 2:19:21 PM EDT
To: Bruce Moskowitz <(b) (6) mac.com>, David Shulkin <Drshulkin@aol.com>, Ike Perlmutter <(b) (6) frenchangel59.com>
Subject: Project Healthy Heroes update

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6/19/2019 12:55 PM
05_ASM09_(b) (6) v32.ppt

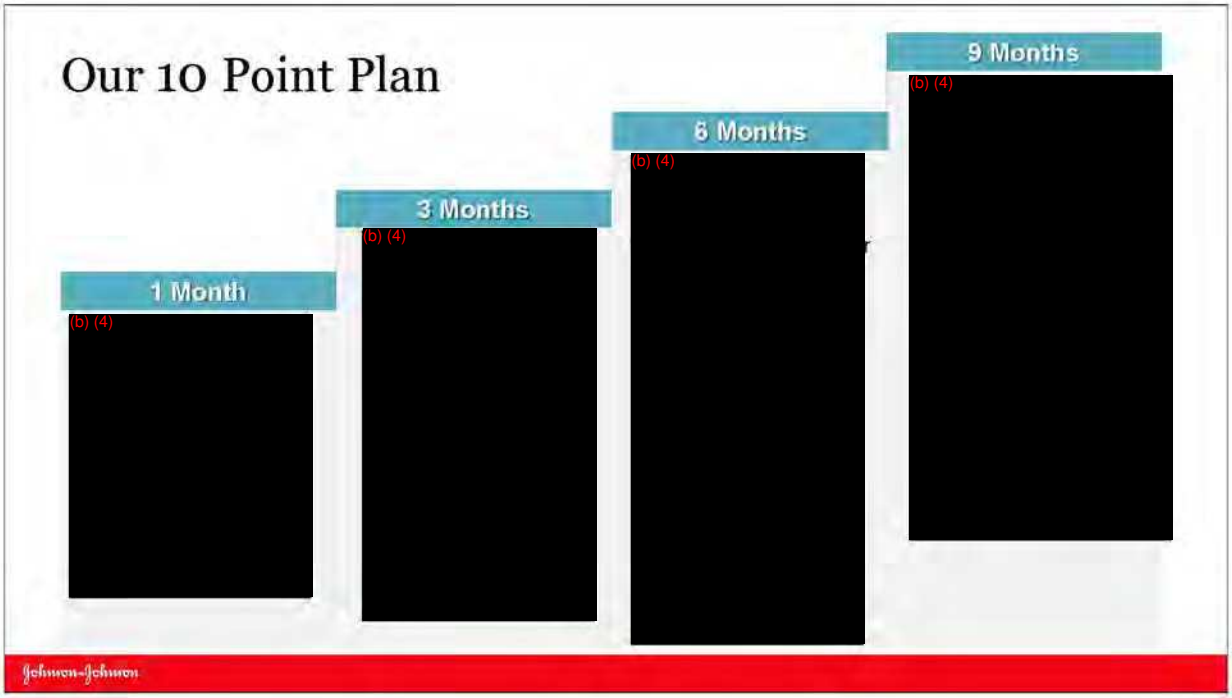
AMERICAN OVERSIGHT



6/19/2019 12:55 PM

05_ASM09_(b) (6) v32.ppt

AMERICAN OVERSIGHT



6/19/2019 12:55 PM

05_ASM09_(b) (6) v32.ppt

AMERICAN OVERSIGHT

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: [redacted] [JSGUS] [redacted]its.jnj.com]
Sent: 4/17/2017 6:19:21 PM
To: Bruce Moskowitz [redacted]mac.com]; David Shulkin [Drshulkin@aol.com]; Ike Perlmutter [redacted]@frenchangel59.com]
Subject: Project Healthy Heroes update
Attachments: HH Project Update_2017_04_17.pptx; ATT00001.txt

AMERICAN OVERSIGHT



6/19/2019 12:44 PM
05_ASM09_(b) (6) v32.ppt

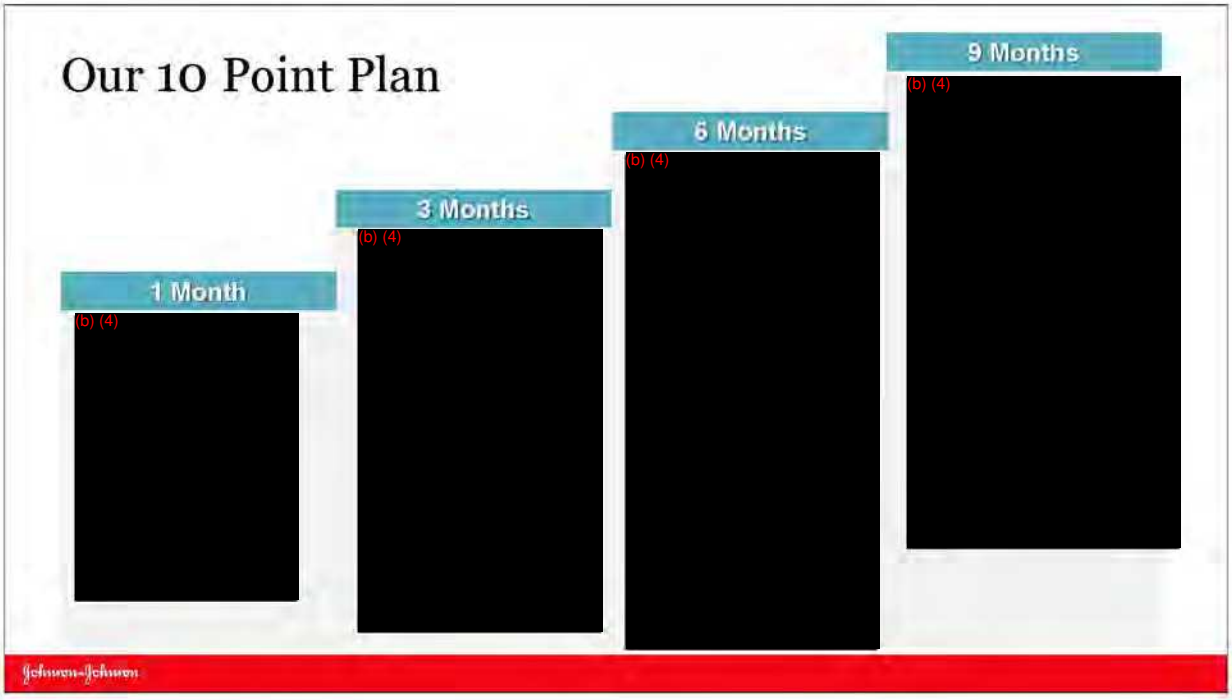
AMERICAN OVERSIGHT



6/19/2019 12:44 PM

05_ASM09_(b) (6) v32.ppt

AMERICAN OVERSIGHT



6/19/2019 12:44 PM

05_ASM09_(b) (6) v32.ppt

AMERICAN OVERSIGHT

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 8:38:15 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: American Association for Physician Leadership Honoring you as Honorary Fellow

Do we know what time i need to be there this day for the event?

Sent from my iPhone

Begin forwarded message:

> **From:** (b) (6) <(b) (6) physicianleaders.org>
> **Date:** March 9, 2017 at 1:44:44 PM EST
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: American Association for Physician Leadership Honoring you as Honorary Fellow**
>
> Terrific David - thanks for considering and it will be a pleasure to have our paths cross again.
>
> All the best - Peter
> (b) (6) MD
> Any typos - it's the phone
>
> On Mar 9, 2017, at 13:42, David shulkin <Drshulkin@aol.com> wrote:
>
> > Thank you (b) (6) this is a true honor. My mom office will reach out to you soon
> >
> > David
> >
> > Sent from my iPhone
> >
> > On Mar 9, 2017, at 1:07 PM, (b) (6) <(b) (6) physicianleaders.org> wrote:
> >
> > > Good Afternoon,
> > >
> > > Please take a moment to read the attached letter from the American Association for Physician Leadership.
> > >
> > > Sincerely – (b) (6)
> > >
> > > (b) (6) MD FRCS(C), FACS, MCCM
> > > President and Chief Operating Officer (CEO)
> > > American Association for Physician Leadership
> > > Tampa, Florida, USA 33602
> > > **Inspiring Change. Together.**
> > > www.physicianleaders.org
> > > **2017 Annual Meeting** | April 22-23, 2017, New York, NY

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<Shulkin_Honorary.pdf>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/10/2017 11:20:20 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: FYI: URGENT | Your Input: VA Public-facing Web site

Nice

Sent from my iPhone

On Apr 10, 2017, at 7:02 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Yes- thanks a ton and really appreciate you talking to us against this evening - you guys are best
>
> Sent from my iPhone
>
> On Apr 10, 2017, at 6:26 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> > Excellent
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.
> >
> > On Apr 10, 2017, at 5:59 PM, (b) (6) (b) (6) mayo.edu> wrote:
> >
> > > Hi – fyi....
> > >
> > > **From:** (b) (6)
> > > **Sent:** Monday, April 10, 2017 4:59 PM
> > > **To:** (b) (6) (b) (6) (b) (6) (b) (6) (b) (6) (b) (6) ccf.org; (b) (6) jhu.edu; (b) (6) (b) (6) ccf.org); (b) (6) (b) (6) kp.org; (b) (6) kp.org; (b) (6) [RO PA]; (b) (6) (b) (6)
> > > **Subject:** URGENT | Your Input: VA Public-facing Web site
> > > **Sensitivity:** Confidential
> > >
> > > ***PLEASE TREAT AS BUSINESS CONFIDENTIAL***
> > >
> > > Hi – on Wednesday, the VA will announce a web site designed for Veterans to make informed decisions about where they receive their health care. The overview of the plan and the project objectives are attached.
> > >
> > > Dr. Bruce Moskowitz routed the plan in late March to the CEO of the five academic medical center organizations, encouraging that the CEOs "express support/confidence" in the plan. Several CEOs expressed in follow-up emails that they would be willing to "voice support for the approach, that it's reflective of the direction the VA needs to move to best support the care of veterans, etc."
> > >
> > > Dr. Poonam Alaigh, VA Acting Under Secretary for Health, Dr. Moskowitz and I spoke late this afternoon – the question: as this rolls

AMERICAN OVERSIGHT

out (going public on Wednesday), would your CEO; or someone you designate in your organization (perhaps a Quality lead; or "digital care/web" lead be open to speaking w/ the news media, sharing perspective on how this reflects a step forward for veterans and reflects what patients are seeking from healthcare providers? If not someone from your organization, would you recommend an industry expert that can talk to these issues w/ news media?

The timeline for this would be tomorrow (Tuesday) or Wednesday, as this news goes public.

Thanks for your consideration.

(b) (6)
Chair | Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905
cell: 507.269.(b) (6) | office: 507.284.(b) (6)
e-mail: (b) (6) mayo.edu

<Access and Quality Tool Implementation Plan.pdf>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/10/2017 11:02:19 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: (b) (6) [(b) (6) mayo.edu]; David Shulkin [drshulkin@aol.com]
Subject: Re: FYI: URGENT | Your Input: VA Public-facing Web site

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>
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> >
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200 First Street S.W. | Rochester, MN 55905
cell: 507.269.(b) (6) | office: 507.284.(b) (6)
e-mail: (b) (6) mayo.edu

<Access and Quality Tool Implementation Plan.pdf>

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/8/2017 3:08:31 PM
To: David shulkin [drshulkin@aol.com]
Subject: Document #2 - SEPARATE REMINDERS FOR JARED KUSHNER DINNER MEETING 4/8/2017 AT 7:30 PM
Attachments: Ike dinner w Jared 040817 v3.docx

See attached. I will call you later about both attachments.

MEMORANDUM

TO: JARED KUSHNER
FROM: IKE PERLMUTTER
SUBJECT: TOPICS/INITIATIVES FOR DISCUSSION
DATE: APRIL 8, 2017
CC:

PHYSICAL INFRASTRUCTURE

1. Concentrate on the 30% good hospitals the VA currently has
2. Approximately 700 vacant and underutilized locations –
    a. Sell right away - the VA must be permitted to utilize the cash for better use.
    b. Let a third party run/manage homeless shelters. They will do a better job.
    c. Do not use the real estate to build more Homeless shelters.

INFORMATION TECHNOLOGY & ELECTRONIC MEDICAL RECORDS SYSTEM

3. The CIO from Mayo Clinic is overseeing (and other institutions are participating in) a search for a new CIO for the Dept. of Veterans Affairs. CIO candidates will be in DC on April 17th for interviews by the VA, Mayo's CIO and others.
4. DOD recently signed a new contract to implement a new system (Cerner) with an initial cost of $4.3 billion and a total budgeted cost of $9 billion. **There is a push for the VA to choose the same Cerner system.**
5. What the VA needs is a system that can **talk to the private hospitals' systems** with which it will be partnering for Veterans medical care **(interoperability among the Public-Private Partnership)**
    a. The Top 5 Academic Medical Centers DO NOT use Cerner and highly recommend against it in favor of another system (EPIC).
    b. EPIC is used by 50% of the hospitals in the US and covers over 120 million patients. Using EPIC, therefore, as the VA IT platform will allow seamless integration with the platform of the majority of community and academic medical centers. As a result, when veterans access care outside the VA system (the choice extension) there can be the necessary access and integration to vital medical information.
    c. This means less cost, easier access to the doctors, patients and soldiers and their medical records.
    d. The VA has confirmed that they are on same page to pursue Epic as EMR of choice instead of Cerner.

AMERICAN OVERSIGHT

e. Cerner has established (what we think is) an artificial barrier...claiming that Cerner cannot talk to EPIC if the VA chooses EPIC. We believe that EPIC will allow for this cross talk. We also believe that the ability of working with the two different platforms is, in reality, an artificial barrier by Cerner that can be resolved if Cerner chooses. **Therefore, Cerner's DOD implementation MUST be instructed talk to whatever system the VA chooses to install. This must be resolved NOW at the DOD/Cerner level**.

STAFFING

6. Freeze "All Hiring" – Not only with the Secretary of the VA but throughout all agencies and departments. Hiring should be done on a case by case basis and only upon the Secretary's approval.
7. Institute an early retirement employee buyout program.
8. Transfer employees from one segment of the VA to another to balance excess workforce and shortages

BUDGETING

9. The FY17 VA budget is over $181 Billion. We are evaluating the budget to identify waste, inefficiencies and potential surpluses.
10. The preliminary goal looks like a potential minimum reduction of $15B.
11. This should be achievable without adding any extra costs and, at the same time, improving quality of and access to care.

PTSD | SUICIDE PREVENTION

12. Establish mandatory new enlistee psych and physical exams (from day one when entering the military to catch problems at the outset and prevent surprises and costs upon retirement)
13. Establish a wellness prevention program. *[As an example, we administer colonoscopy exams for early detection of cancer. If the disease is discovered early we can save lives and reduce costs]*

WHITE HOUSE LIAISON

14. The VA transformation process is moving quickly and effectively by leaning on the expertise of the team I assembled (hospital, medical and restructuring experts). The effort is more efficiently and effectively managed as a unified, singular effort. To be most efficient (and successful) the White House staff would contribute best if focused on opening doors and removing political obstacles, when requested, but not on overseeing their own initiatives. Currently, our group doesn't need to inconvenience (b) (6) (b) (6) and her group, but needs them available (on call) when requested. For our continuing needs, we can interface with (b) (6) which will also develop him as an operator in business as well.

OTHER

15. *PRESIDENT'S INVITATION*
    a. (b) (6) 's initiative is gathering 500 people in Washington on April 29th at 7:00 PM. He is working with the Pastor, Dr (b) (6) . The party will take place in the Trump Hotel in Washington. It will be televised and Fox's Hannity will attend and we would like the President to attend.

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:32:18 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re: VA CIO Search

Wow- your amazing!

Sent from my iPhone

On Apr 6, 2017, at 7:22 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> I should have four to interview at end of today
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> On Apr 6, 2017, at 7:21 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Ike- I had seen an email yesterday that Bruce was asked to try to identify some additional
> > Names as a backup for CIO and i wondered if the below offer was useful to us or not.
> >
> > What do you think?
> >
> > David
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** Bruce Moskowitz <(b) (6) mac.com>
> > **Date:** April 6, 2017 at 5:50:36 AM EDT
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Re: VA CIO Search**
> >
> > Ike would know more than I would
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.
> >
> > On Apr 5, 2017, at 10:08 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > Bruce - we can pursue this if helpful
> > >
> > > David

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-----Original Message-----
From: [redacted]
[redacted]ourpublicservice.org]
Sent: Wednesday, April 05, 2017 05:34 PM Eastern Standard Time
To: Blackburn, Scott R.
Subject: [EXTERNAL] VA CIO Search

Scott:

The purpose of this note is to put another important issue on your radar screen. Following up on the conversation with you and David about your talent needs, I've spoken to the CIO practice leaders at Heidrick & Struggles and they have agreed to work together on a pro bono basis to find you the best possible CIO candidates. I've connected them with Gina and the GC's office has signed off on accepting the help under your gift acceptance authority.

I know you have a very full plate but I think your direct involvement with them is most likely to lead to your getting the best talent. They are truly top drawer and I don't think VA is used to having that kind of assistance. Would it help to have a very quick call on this?

Best,

[redacted]

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/6/2017 11:22:32 AM
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Bruce Moskowitz M.D.

On Apr 6, 2017, at 7:21 AM, David shulkin <Drshulkin@aol.com> wrote:

> Ike- I had seen an email yesterday that Bruce was asked to try to identify some additional Names as a backup for CIO and i wondered if the below offer was useful to us or not.
>
> What do you think?
>
> David
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** Bruce Moskowitz <(b) (6) mac.com>
> > **Date:** April 6, 2017 at 5:50:36 AM EDT
> > **To:** David Shulkin <drshulkin@aol.com>
> > **Subject: Re: VA CIO Search**
> >
> > Ike would know more than I would
> >
> > Sent from my iPad
> > Bruce Moskowitz M.D.
> >
> > On Apr 5, 2017, at 10:08 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > Bruce - we can pursue this if helpful
> > >
> > > David
> > >
> > > -----Original Message-----
> > > **From:** (b) (6) [(b) (6) ourpublicservice.org]
> > > **Sent:** Wednesday, April 05, 2017 05:34 PM Eastern Standard Time
> > > **To:** Blackburn, Scott R.
> > > **Subject:** [EXTERNAL] VA CIO Search
> > >
> > > Scott:

AMERICAN OVERSIGHT

The purpose of this note is to put another important issue on your radar screen. Following up on the conversation with you and David about your talent needs, I've spoken to the CIO practice leaders at Heidrick & Struggles and they have agreed to work together on a pro bono basis to find you the best possible CIO candidates. I've connected them with Gina and the GC's office has signed off on accepting the help under your gift acceptance authority.

I know you have a very full plate but I think your direct involvement with them is most likely to lead to your getting the best talent. They are truly top drawer and I don't think VA is used to having that kind of assistance. Would it help to have a very quick call on this?

Best,

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:21:28 AM
To: Ike Perlmutter [(b) (6)frenchangel59.com]
CC: Bruce Moskowitz [(b) (6) mac.com]
Subject: Fwd: VA CIO Search

Ike- I had seen an email yesterday that Bruce was asked to try to identify some additional Names as a backup for CIO and i wondered if the below offer was useful to us or not.

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David

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
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AMERICAN OVERSIGHT

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Best,

(b) (6)

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) [redacted]mac.com]
Sent: 4/6/2017 9:50:36 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: VA CIO Search

Ike would know more than I would

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 5, 2017, at 10:08 PM, David Shulkin <drshulkin@aol.com> wrote:

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>
> David
>
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> **From:** (b) (6) [redacted] [(b) (6) [redacted]ourpublicservice.org]
> **Sent:** Wednesday, April 05, 2017 05:34 PM Eastern Standard Time
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> **Subject:** [EXTERNAL] VA CIO Search
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> Scott:
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> I hope all is well and the leadership retreat preparation is going well from your perspective. I know my colleagues Tom, Chris and Michelle have very much enjoyed working with you and the VA team.
>
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AMERICAN OVERSIGHT

Best,

(b) (6)

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/6/2017 2:08:40 AM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Fwd: VA CIO Search

Bruce - we can pursue this if helpful

David

-----Original Message-----
From: (b) (6) [(b) (6) ourpublicservice.org]
Sent: Wednesday, April 05, 2017 05:34 PM Eastern Standard Time
To: Blackburn, Scott R.
Subject: [EXTERNAL] VA CIO Search

Scott:

I hope all is well and the leadership retreat preparation is going well from your perspective. I know my colleagues Tom, Chris and Michelle have very much enjoyed working with you and the VA team.

The purpose of this note is to put another important issue on your radar screen. Following up on the conversation with you and David about your talent needs, I've spoken to the CIO practice leaders at Heidrick & Struggles and they have agreed to work together on a pro bono basis to find you the best possible CIO candidates. I've connected them with Gina and the GC's office has signed off on accepting the help under your gift acceptance authority.

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Best,

(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 1:13:53 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Amtrak

Sundays 73EA12

Sent from my iPhone

> On Apr 6, 2017, at 8:50 PM, (b) (6) <(b) (6) gmail.com> wrote:
>
> Don't forget to send

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 1:13:14 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Amtrak

Reservation 7546E9

Did we ever get the travel company to add my guest rewards to my trips in the past, including monday?
Rewards (b) (6)

Sent from my iPhone

> On Apr 6, 2017, at 8:50 PM, (b) (6) <(b) (6) gmail.com> wrote:
>
> Don't forget to send

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/7/2017 12:50:13 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Amtrak

Don't forget to send

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/7/2017 8:05:01 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: The Situation Report: Is the CIO Job at VA About to Lose Its Influence?

Game changing bold move

Sent from my iPhone

On Apr 7, 2017, at 3:46 PM, David shulkin <Drshulkin@aol.com> wrote:

> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** Michael Tepper (b) (6) @yahoo.com>
> > **Date:** April 7, 2017 at 12:32:02 PM EDT
> > **To:** "David J. Shulkin" <DrShulkin@aol.com>
> > **Subject: The Situation Report: Is the CIO Job at VA About to Lose Its Influence?**
> > **Reply-To:** (b) (6) @yahoo.com
> >
> > https://www.meritalk.com/the-situation-report-is-the-cio-job-at-va-about-to-lose-its-influence/

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 7:40:32 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: The Situation Report: Is the CIO Job at VA About to Lose Its Influence?

Sent from my iPhone

Begin forwarded message:

From: Michael Tepper <(b) (6) @yahoo.com>
Date: April 7, 2017 at 12:32:02 PM EDT
To: "David J. Shulkin" <DrShulkin@aol.com>
Subject: The Situation Report: Is the CIO Job at VA About to Lose Its Influence?
Reply-To: (b) (6) @yahoo.com

https://www.meritalk.com/the-situation-report-is-the-cio-job-at-va-about-to-lose-its-influence/

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/21/2017 5:31:12 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: partnership opportunities

Bruce- i think she is definitely on target

David

Sent from my iPhone

On Apr 21, 2017, at 12:26 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> Thank you I will ask the Secretary and acting undersecretary to review with me
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> On Apr 20, 2017, at 8:57 AM, (b) (6) (NOLA) <(b) (6) va.gov> wrote:
>
> > Good morning, Bruce –
> >
> > Thank you again for your interest in the work that I am leading, and I look forward to identifying synergies to maximize our collective impact. As I mentioned, of the 20 Veterans who are dying by suicide every day, 14 are not engaged in VA care. While it is our responsibility to support all 22 million Veterans, the greatest need (and potential impact) is with those who are NOT engaging in VA healthcare. Pursuant to targeting these "14", I have built relationships with leaders from organizations outlined in the attached and have highlighted partnerships that could be expanded for greater impact.
> >
> > In addition, my team is working to partner with organizations that help us reach large concentrations of Veterans (before they are in crisis) while simultaneously developing an integrated and comprehensive public health strategy that is executed in local communities nationally. Specifically, we are interested in exploring opportunities in healthcare for the following:
> >
> > 1. <!--[if !supportLists]--><!--[endif]-->Partnerships with private sector healthcare companies to provide training in suicide risk assessment for physicians, nurse practitioners, and nurses working in Primary Care and Emergency Room settings;
> > 2. <!--[if !supportLists]--><!--[endif]-->Partnership with professional associations such as American Academy of Family Physicians, American Nurses Association, etc. to promote training programs for community/private sector providers.
> >
> > I look forward to any ideas that you have and the opportunity to discuss next steps. Thank you for all that you are doing to support Veterans and VA. We must succeed.
> >
> > With sincere appreciation and respect,
> > (b) (6)

AMERICAN OVERSIGHT

(b) (6) [redacted]

National Director, Public-Private Partnerships (Acting)
Department of Veterans Affairs
Office for Suicide Prevention

NEW PHONE: 561-701-(b) (6) [redacted]
Email: (b) (6) [redacted] va.gov

<OSP National Strategic Partnerships Opportunities.docx>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/21/2017 4:26:58 PM
To: (b) (6) (NOLA) [(b) (6) va.gov]
CC: Poonam Alaigh [(b) (6) hotmail.com]; David shulkin [drshulkin@aol.com]
Subject: Re: partnership opportunities

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Sent from my iPad
Bruce Moskowitz M.D.

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> (b) (6)
>
> [redacted]
>
> National Director, Public-Private Partnerships (Acting)
> Department of Veterans Affairs
> Office for Suicide Prevention
>
> **NEW PHONE**: 561-701-(b) (6)
> **Email:** (b) (6) va.gov
>
> <OSP National Strategic Partnerships Opportunities.docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 10:02:54 PM
To: Va David [vacodjs1@va.gov]
Subject: Fwd: Another CIO Yale
Attachments: Biosketch_[redacted]_2017PMC.docx; Untitled attachment 05404.htm

Sent from my iPhone

Begin forwarded message:

From: Bruce Moskowitz <[redacted]mac.com>
Date: April 7, 2017 at 3:29:07 PM EDT
To: drshulkin@aol.com
Cc: IP <[redacted]frenchangel59.com>
Subject: Another CIO Yale

AMERICAN OVERSIGHT

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. DO NOT EXCEED FIVE PAGES.

NAME: [redacted]

eRA COMMONS USER NAME (credential, e.g., agency login): [redacted]

POSITION TITLE: Professor, Yale University

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
[redacted]			

A. Personal Statement

[redacted]

AMERICAN OVERSIGHT

B. Positions and Honors

Positions and Employment

(b) (6), (b) (2)

[redacted]

National Appointments

(b) (6), (b) (2)

[redacted]

C. Contributions to Science

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Complete List of Published Work in MyBibliography:

(b) (6), (b) (2)

[redacted]

D. Additional Information: Research Support and/or Scholastic Performance

Current Research Support

NIH Grants:

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)



VA Grants

(b) (6), (b) (2)



AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/7/2017 7:29:07 PM
To: drshulkin@aol.com
CC: IP [(b) (6) frenchangel59.com]
Subject: Another CIO Yale
Attachments: Biosketch_(b) (6), _2017PMC.docx; Untitled attachment 05410.txt

AMERICAN OVERSIGHT

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
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AMERICAN OVERSIGHT

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[redacted]

National Appointments

(b) (6), (b) (2)

[redacted]

C. Contributions to Science

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Complete List of Published Work in MyBibliography:

(b) (6), (b) (2)

[redacted]

D. Additional Information: Research Support and/or Scholastic Performance

Current Research Support

NIH Grants:

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

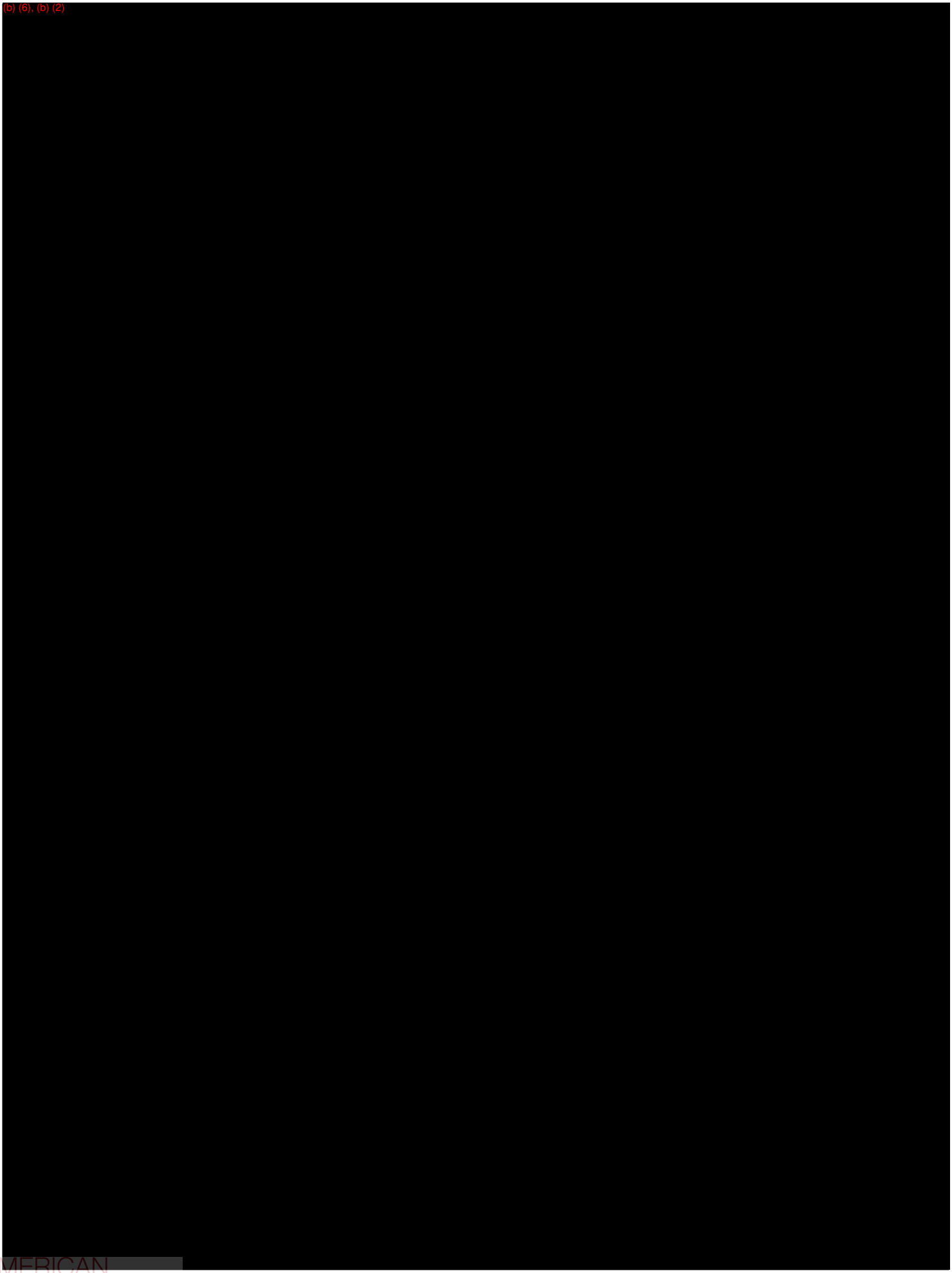
[redacted]

VA Grants

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/12/2017 1:51:24 AM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: Passover seder

I love it! Thank you.

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Tuesday, April 11, 2017 6:38 PM
To: Ike Perlmutter
Subject: Fwd: Passover seder

Ike- youll enjoy this

Subject: Re: Passover seder

http://www.timesofisrael.com/trump-a-no-show-at-white-house-seder/

Sent via the Samsung Galaxy S® 5 ACTIVE™, an AT&T 4G LTE smartphone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/11/2017 10:37:32 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]
Subject: Fwd: Passover seder

Ike- youll enjoy this

Subject: Re: Passover seder

http://www.timesofisrael.com/trump-a-no-show-at-white-house-seder/

Sent via the Samsung Galaxy S® 5 ACTIVE™, an AT&T 4G LTE smartphone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/15/2017 5:07:06 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Just sent in seperate message

On Apr 15, 2017 1:05 PM, "[redacted]" <[redacted]gmail.com> wrote:
Yes stand by

On Apr 15, 2017 1:04 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Do you have one of those screen shots from the access paper for the annals I can use for my studer slides? If so can you send?

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/15/2017 5:05:03 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Yes stand by

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Sent from my iPhone

AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 4/15/2017 5:04:37 PM
To: (b) (6) [(b) (6) gmail.com]

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 3:20:29 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Call me in the morning

K

Sent from my iPhone

> On Apr 5, 2017, at 11:19 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> On your way to work in the morning if that is the best time
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/6/2017 3:19:21 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Call me in the morning

On your way to work in the morning if that is the best time

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 11:21:31 PM
To: IP [(b) (6)frenchangel59.com]
Subject: Re: Lab Soft News: Cerner/Leidos/Accenture Secure EHR Contract for a Global Military EHR

Bruce and I spoke and we definitely want to pursue an Epic option through one of our partners. The Department of Defense option is worth exploring as well as Congress has been urging VA and DOD to work together on electronic records for over a decade.

Sent from my iPhone

On Apr 7, 2017, at 6:49 PM, IP <(b) (6) frenchangel59.com> wrote:

This was posted in 2015....

Do you think it makes sense to share this with the people I am seeing this weekend?

http://labsoftnews.typepad.com/lab_soft_news/2015/08/cerner-dod-contract-conn.html

Cerner/Leidos/Accenture Secure EHR Contract for a Global Military EHR

I have waited about five days to comment about the success of Cerner and its partners with the DOD EHR contract. This has allowed me to collect my thoughts and review some of the other articles covering the news. I thought that the best analysis I have read was by *Joseph Conn* of *Modern Healthcare* (see: Cerner, Leidos and Accenture win massive Defense contract for EHR system). Below are some quotes from his article:

For the better part of a year, Epic has been buffeted by charges from its critics, competitors and various members of Congress about an alleged lack of interoperability of its system....*Chris Miller, program executive officer of defense health management systems, the Defense Department office that handled the DHMSM procurement, said the buyers were acutely aware of the data-blocking issue....*

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Dr. Howard Landa....previously worked in medical informatics for Kaiser Permanente, including during the 2003 through 2007 period when it switched from multiple home-grown EHRs to Epic. ***The worry then was that Kaiser, with its 36 hospitals, would drain Epic's resources from its other customers. That largely didn't happen. Now, that monkey will be on Cerner's back....***

*L****eidos, formerly the national security, health and engineering business of defense contractor Science Applications International Corp, was spun off from SAIC in 2013. In the late 1980s and early 1990s, SAIC, operating on a $1.1 billion Defense Department contract, created and installed the Composite Health Care System for the military health system.*** *CHCS I, which is still in use, was based on public domain software code provided free by the VA from an early version of what is now the VA's VistA EHR....*

Todd Cozzens..., a noted venture capital firm in the information technology industry, said interoperability is a key issue.*"The No. 1 focus of the DoD, the ONC and others should be, not only is this system useful, but can it interoperate" with other vendors' EHRs, Cozzens said.* ***"There's so little emphasis on making these systems interoperable," Cozzens said. "We really failed as an industry to do that."....***

Perhaps in anticipation of good news from the Defense Department, Cerner stock prices jumped nearly 7.2% on the day, closing an hour before the award was announced at $73.40 a share. *Miller said the military has more than 50 systems it is planning to replace with the new Cerner installation.*

I believe that Cerner has been preoccupied with Wall Street and its quarterly earnings since it went public. The same charge cannot be leveled against Epic which is privately held and generally uninterested in marketing or hyping its product. The company depends largely on referrals and word of mouth. This new contract is certainly good news for Cerner stockholders because the company will now be feeding at the "Uncle Sugar" trough for many years to come. This new relationship with the DOD will push Cerner further down the path of a

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de facto governmental contractor like its partner Leidos. I can't say that this will necessarily hurt the services and products that Cerner provides to its current hospital clients but I am sure that they are not going to get any better.

As to Epic "failure" to win the contract, I suspect that there were a lot of smiles of relief in Verona when the winner was announced. I think that Epic was competing in the contest because everyone expected it to do so. The Epic culture and emphasis on client control was probably a non-starter for the military brass. Leidos/SAIC contrariwise was a known quantity for them. Epic has almost a lock on the EHR business for the larger and most prestigious U.S. hospitals and success with a DOD contract would have done little to burnish the company image. It will just keep on rolling, closing more deals in the U.S. and beefing up its international set of clients. Here's a quote from another article reinforcing this same idea (see: CIOs 'surprised' at Cerner DoD win):

In addition to partner strength, ...[an EHR expert] believes Cerner likely had the upper hand in terms of sales skills. ***"Cerner is a selling machine and they do a very good job of selling their product," ...[he noted]. "Epic thinks they are the de facto winner all the time and they don't know how to sell because they haven't needed to sell.*** *"But that's not how the government works.* ***They have a whole process they go through and Epic isn't geared to deal with that.***

One more thing. What's the chance of Cerner/Leidos/Accenture actually succeeding in this huge, global EHR military/VA integration project? I and many informed observers put the chances of success at slim to none. *Ross Koppel's* quote below accurately reflects my opinion (see: Cerner is part of team that wins huge contract to revamp military's health records):

Some analysts were skeptical that any of the bidders was up to the task. *In the end, the Pentagon had a choice among three finalists who offered fairly mediocre systems for the price, said Ross Koppel, a professor of sociology at the University of Pennsylvania who studies health information technology.* ***"All the systems are stunningly clunky,***

AMERICAN OVERSIGHT

the interfaces are state of the art 15 years ago, the usability is far inferior to every other system of the modern era, and the lack of interoperability makes a hash of the data," Koppel said.

So, here's what's I think is going to happen? A year or two from now, Cerner/Leidos/Accenture will announce a *huge victory* in installing and integrating the Cerner EHR in a large Army hospital and a few free-standing clinics. Then, total "radio silence" for five or six years. Then a DOD spokesperson will announce that the military is unhappy with the EHR contractors who have not lived up to the terms of the contract in addition to being responsible for cost overruns with the cost swelling to, say, $15 billion with little to show for it. This latter news will not receive much media coverage.

Posted by Bruce Friedman on August 03, 2015 at 12:42 PM in Electronic Health Record (EHR), Healthcare Business, Healthcare Delivery, Healthcare Information Technology, Pathology Informatics | Permalink

-
-

<Cerner.docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 11:03:28 PM
To: IP [(b) (6)frenchangel59.com]
Subject: Re: Lab Soft News: Cerner/Leidos/Accenture Secure EHR Contract for a Global Military EHR

Yes

Sent from my iPhone

On Apr 7, 2017, at 6:49 PM, IP <(b) (6) frenchangel59.com> wrote:

This was posted in 2015....

Do you think it makes sense to share this with the people I am seeing this weekend?

http://labsoftnews.typepad.com/lab_soft_news/2015/08/cerner-dod-contract-conn.html

Cerner/Leidos/Accenture Secure EHR Contract for a Global Military EHR

I have waited about five days to comment about the success of Cerner and its partners with the DOD EHR contract. This has allowed me to collect my thoughts and review some of the other articles covering the news. I thought that the best analysis I have read was by *Joseph Conn* of *Modern Healthcare* (see: Cerner, Leidos and Accenture win massive Defense contract for EHR system). Below are some quotes from his article:

For the better part of a year, Epic has been buffeted by charges from its critics, competitors and various members of Congress about an alleged lack of interoperability of its system.*...Chris Miller, program executive officer of defense health management systems, the Defense Department office that handled the DHMSM procurement, said the buyers were acutely aware of the data-blocking issue....*

AMERICAN OVERSIGHT

Dr. Howard Landa....previously worked in medical informatics for Kaiser Permanente, including during the 2003 through 2007 period when it switched from multiple home-grown EHRs to Epic. ***The worry then was that Kaiser, with its 36 hospitals, would drain Epic's resources from its other customers. That largely didn't happen. Now, that monkey will be on Cerner's back....***

Leidos, formerly the national security, health and engineering business of defense contractor Science Applications International Corp, was spun off from SAIC in 2013. In the late 1980s and early 1990s, SAIC, operating on a $1.1 billion Defense Department contract, created and installed the Composite Health Care System for the military health system. *CHCS I, which is still in use, was based on public domain software code provided free by the VA from an early version of what is now the VA's VistA EHR....*

Todd Cozzens..., a noted venture capital firm in the information technology industry, said interoperability is a key issue. *"The No. 1 focus of the DoD, the ONC and others should be, not only is this system useful, but can it interoperate" with other vendors' EHRs, Cozzens said.* ***"There's so little emphasis on making these systems interoperable," Cozzens said. "We really failed as an industry to do that."....***

Perhaps in anticipation of good news from the Defense Department, Cerner stock prices jumped nearly 7.2% on the day, closing an hour before the award was announced at $73.40 a share. *Miller said the military has more than 50 systems it is planning to replace with the new Cerner installation.*

I believe that Cerner has been preoccupied with Wall Street and its quarterly earnings since it went public. The same charge cannot be leveled against Epic which is privately held and generally uninterested in marketing or hyping its product. The company depends largely on referrals and word of mouth. This new contract is certainly good news for Cerner stockholders because the company will now be feeding at the "Uncle Sugar" trough for many years to come. This new relationship with the DOD will push Cerner further down the path of a

AMERICAN OVERSIGHT

de facto governmental contractor like its partner Leidos. I can't say that this will necessarily hurt the services and products that Cerner provides to its current hospital clients but I am sure that they are not going to get any better.

As to Epic "failure" to win the contract, I suspect that there were a lot of smiles of relief in Verona when the winner was announced. I think that Epic was competing in the contest because everyone expected it to do so. The Epic culture and emphasis on client control was probably a non-starter for the military brass. Leidos/SAIC contrariwise was a known quantity for them. Epic has almost a lock on the EHR business for the larger and most prestigious U.S. hospitals and success with a DOD contract would have done little to burnish the company image. It will just keep on rolling, closing more deals in the U.S. and beefing up its international set of clients. Here's a quote from another article reinforcing this same idea (see: CIOs 'surprised' at Cerner DoD win):

In addition to partner strength, ...[an EHR expert] believes Cerner likely had the upper hand in terms of sales skills. ***"Cerner is a selling machine and they do a very good job of selling their product," ...[he noted]. "Epic thinks they are the de facto winner all the time and they don't know how to sell because they haven't needed to sell.*** *"But that's not how the government works.* ***They have a whole process they go through and Epic isn't geared to deal with that.***

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AMERICAN OVERSIGHT

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So, here's what's I think is going to happen? A year or two from now, Cerner/Leidos/Accenture will announce a *huge victory* in installing and integrating the Cerner EHR in a large Army hospital and a few free-standing clinics. Then, total "radio silence" for five or six years. Then a DOD spokesperson will announce that the military is unhappy with the EHR contractors who have not lived up to the terms of the contract in addition to being responsible for cost overruns with the cost swelling to, say, $15 billion with little to show for it. This latter news will not receive much media coverage.

Posted by Bruce Friedman on August 03, 2015 at 12:42 PM in Electronic Health Record (EHR), Healthcare Business, Healthcare Delivery, Healthcare Information Technology, Pathology Informatics | Permalink

-
-

<Cerner.docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 2:03:30 AM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Lab Soft News: Cerner/Leidos/Accenture Secure EHR Contract for a Global Military EHR

Interesting

Sent from my iPhone

> On Apr 4, 2017, at 6:40 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
>
> http://labsoftnews.typepad.com/lab_soft_news/2015/08/cerner-dod-contract-conn.html
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/4/2017 10:40:56 PM
To: IP [(b) (6) frenchangel59.com]; mbs(b) (6) @gmail.com
CC: drshulkin@aol.com
Subject: Lab Soft News: Cerner/Leidos/Accenture Secure EHR Contract for a Global Military EHR

http://labsoftnews.typepad.com/lab_soft_news/2015/08/cerner-dod-contract-conn.html

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/25/2017 5:05:13 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]; Marisol [(b) (6) frenchangel59.com]

Tom Bowman will come to dinner so the senate efforts are represented. I would have invited the number 2 republican on the committee but they all are going to the senate spouses dinner

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 5/23/2017 11:50:29 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Terry Fadem

You will be simply great!!

Sent from my iPhone

On May 23, 2017, at 5:28 PM, David shulkin <Drshulkin@aol.com> wrote:

> Ok - thats a big assumption about my state of mind tommorow
>
> Sent from my iPhone
>
> On May 23, 2017, at 4:58 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Let's talk about this tomorrow after your hearing when you have a clearer mind- we can do it hourly - spoke to Rachel
> >
> > Sent from my iPhone
> >
> > On May 23, 2017, at 7:33 AM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > > Can you see if Rachels group in technology transfer has done anything about a contract with Terry Fadem- ive asked three times
> > >
> > > We have to be careful he would need to work for the technology transfer group as a consultant as Bruce cannot direct his activities since he is not a federal employee- he must work for TTp- maybe On an hourly basis
> > >
> > > We need to do this by the rules or lets not do it
> > >
> > > Sent from my iPhone
> > >
> > > Begin forwarded message:
> > >
> > > **From:** Bruce Moskowitz <(b) (6) mac.com>
> > > **Date:** May 23, 2017 at 6:40:45 AM EDT
> > > **To:** drshulkin@aol.com
> > > **Cc:** L Perl <(b) (6) gmail.com>, IP <(b) (6) frenchangel59.com>, mbs(b) (6) @gmail.com
> > > **Subject: Terry Fadem**
> > >
> > > EMCL

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/23/2017 9:23:54 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Terry Fadem

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Sent from my iPhone

On May 23, 2017, at 4:58 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

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> > **To:** drshulkin@aol.com
> > **Cc:** L Perl <(b) (6) gmail.com>, IP <(b) (6) frenchangel59.com>, mbs(b) (6) @gmail.com
> > **Subject: Terry Fadem**
> >
> > EMCL

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 5/23/2017 8:58:53 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Terry Fadem

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Sent from my iPhone

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> **From:** Bruce Moskowitz <(b) (6) mac.com>
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> **Cc:** L Perl <(b) (6) gmail.com>, IP <(b) (6) frenchangel59.com>, mbs(b) (6) @gmail.com
> **Subject: Terry Fadem**
>
> EMCL

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/23/2017 11:33:08 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Terry Fadem

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Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** May 23, 2017 at 6:40:45 AM EDT
> **To:** drshulkin@aol.com
> **Cc:** L Perl <(b) (6) gmail.com>, IP <(b) (6) frenchangel59.com>, mbs(b) (6) @gmail.com
> **Subject: Terry Fadem**
>
> EMCL

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/23/2017 11:26:56 AM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Terry Fadem

Of course

Sent from my iPhone

> On May 23, 2017, at 7:15 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Thank you is it possible to let him know?
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
>> On May 23, 2017, at 7:13 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Bruce- we are working on this- i know it seems crazy but this is the toughest thing to do in government- since it deals with procurement and you need to bid things our and give preferences to disabled veteran owned businesses- but we are getting close
>>
>>
>>
>> Sent from my iPhone
>>
>>> On May 23, 2017, at 6:40 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>>
>>> We need to know what is timeline for his approval. I can not get needed technology donated from the group without his assistance. We have the following waiting for his assistance:
>>>
>>> Off the shelf programs for Inventory management that do not rely on EMR and can start tracking unnecessary spending immediately
>>> Your internal group headed by your current CIO wants the EMCL software so Veterans can access care at reliable health care clinics and know wait times under the choice program.
>>>
>>> Program tracking opioid prescriptions and overprescribing.
>>>
>>> Suicide and mental health tracking who is at risk.
>>>
>>> Thank you for the update.
>>> Sent from my iPad
>>> Bruce Moskowitz M.D.
>>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 5/23/2017 11:15:19 AM
To: David shulkin [Drshulkin@aol.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Marc Sherman [(b) (6) gmail.com]
Subject: Re: Terry Fadem

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Sent from my iPad
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>> Sent from my iPad
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/23/2017 11:13:35 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Marc Sherman [(b) (6) gmail.com]
Subject: Re: Terry Fadem

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AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 5/23/2017 10:40:45 AM
To: drshulkin@aol.com
CC: L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; (b) (6) gmail.com
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 7:47:05 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Document #1 - REMINDERS FOR DINNER WITH JARED KUSHNER - Saturday, April 8th at 7:30 PM

I agree - well have to think this through

Sent from my iPhone

On Apr 8, 2017, at 3:37 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Lost for words- had to re-read it a few times, but the good thing is that he looped you in - we just have to find ways to meet with them face to face on a regular basis- not just the quick daily calls. They have to get to know you over time, build trust and recognize you as the ultimate authority- not just quick phone calls
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>
> > Omg
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** "IP" <(b) (6) frenchangel59.com>
> > **Date:** April 8, 2017 at 11:02:47 AM EDT
> > **To:** "David shulkin" <drshulkin@aol.com>
> > **Subject: Document #1 - REMINDERS FOR DINNER WITH JARED KUSHNER - Saturday, April 8th at 7:30 PM**
> >
> > See attached. I will call you later today.
> >
> > ---
> >
> > **MEMORANDUM**
> >
> > ---
> >
> > **TO:** JARED KUSHNER
> > **FROM:** IKE PERLMUTTER
> > **SUBJECT:** TOPICS/INITIATIVES FOR DISCUSSION
> > **DATE:** APRIL 8, 2017
> > **CC:**
> >
> > ---
> >
> > **PHYSICAL INFRASTRUCTURE**
> >
> > 1. Concentrate on the 30% good hospitals the VA currently has

AMERICAN OVERSIGHT

2. Approximately 700 vacant and underutilized locations –

    a. Sell right away - the VA must be permitted to utilize the cash for better use.

    b. Let a third party run/manage homeless shelters. They will do a better job.

    c. Do not use the real estate to build more Homeless shelters.

INFORMATION TECHNOLOGY

3. The CIO from Mayo Clinic is overseeing (and other institutions are participating in) a search for a new CIO for the Dept. of Veterans Affairs. CIO candidates will be in DC on April 17th for interviews by the VA, Mayo's CIO and others.

STAFFING

4. Freeze "All Hiring" – Not only with the Secretary of the VA but throughout all agencies and departments. Hiring should be done on a case by case basis and only upon the Secretary's approval.

5. Institute an early retirement employee buyout program.

6. Transfer employees from one segment of the VA to another to balance excess workforce and shortages

BUDGETING

7. The FY17 VA budget is over $181 Billion. We are evaluating the budget to identify waste, inefficiencies and potential surpluses.

8. The preliminary goal looks like a potential minimum reduction of $15B.

9. This should be achievable without adding any extra costs and, at the same time, improving quality of and access to care.

PTSD | SUICIDE PREVENTION

10. Establish mandatory new enlistee psych and physical exams (from day one when entering the military to catch

AMERICAN OVERSIGHT

problems at the outset and prevent surprises and costs upon retirement)

11. Establish a wellness prevention program. *[As an example, we administer colonoscopy exams for early detection of cancer. If the disease is discovered early we can save lives and reduce costs]*

INFORMATION TECH | ELECTRONIC MEDICAL RECORDS SYSTEM

12. DOD recently signed a new contract to implement a new system (Cerner) with an initial cost of $4.3 billion and a total budgeted cost of $9 billion. **There is a push for the VA to choose the same Cerner system.**

13. What the VA needs is a system that can **talk to the private hospitals' systems** with which it will be partnering for Veterans medical care **(interoperability among the Public-Private Partnership)**

    a. The Top 5 Academic Medical Centers DO NOT use Cerner and highly recommend against it in favor of another system (EPIC).

    b. EPIC is used by 50% of the hospitals in the US and covers over 120 million patients.

    c. This means less cost, easier access to the doctors, patients and soldiers and their medical records.

    d. Cerner's DOD implementation then MUST be instructed talk to whatever system the VA chooses to install.

WHITE HOUSE LIAISON

14. The VA transformation process is moving quickly and effectively by leaning on the expertise of the team I assembled (hospital, medical and restructuring experts). The effort is more efficiently and effectively managed as a unified, singular effort. To be most efficient (and successful) the White House staff would contribute best if focused on opening doors and removing political obstacles, when requested, but not on overseeing their own initiatives. Currently, our group doesn't need to inconvenience (b) (6) (b) (6) and her group, but needs them available (on call) when requested. For our continuing needs, we can interface with (b) (6) which will also develop him as an operator in business as well.

AMERICAN OVERSIGHT

OTHER

15. PRESIDENT'S INVITATION

a. (b) (6) initiative is gathering 500 people in Washington on April 29th at 7:00 PM. He is working with the Pastor, Dr (b) (6). The party will take place in the Trump Hotel in Washington. It will be televised and Fox's Hannity will attend and we would like the President to attend.

<Ike dinner w Jared 040817.docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/8/2017 7:37:10 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Document #1 - REMINDERS FOR DINNER WITH JARED KUSHNER - Saturday, April 8th at 7:30 PM

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Sent from my iPhone

On Apr 8, 2017, at 11:20 AM, David shulkin <Drshulkin@aol.com> wrote:

> Omg
>
> Sent from my iPhone
>
> Begin forwarded message:
>
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> **Date:** April 8, 2017 at 11:02:47 AM EDT
> **To:** "David shulkin" <drshulkin@aol.com>
> **Subject: Document #1 - REMINDERS FOR DINNER WITH JARED KUSHNER - Saturday, April 8th at 7:30 PM**
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DATE: APRIL 8, 2017
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AMERICAN OVERSIGHT

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PTSD | SUICIDE PREVENTION

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INFORMATION TECH | ELECTRONIC MEDICAL RECORDS SYSTEM

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13. What the VA needs is a system that can **talk to the private hospitals' systems** with which it will be partnering for Veterans medical care **(interoperability among the Public-Private Partnership)**

AMERICAN OVERSIGHT

a. The Top 5 Academic Medical Centers DO NOT use Cerner and highly recommend against it in favor of another system (EPIC).

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d. Cerner's DOD implementation then MUST be instructed talk to whatever system the VA chooses to install.

WHITE HOUSE LIAISON

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OTHER

15. PRESIDENT'S INVITATION

a. (b) (6) 's initiative is gathering 500 people in Washington on April 29th at 7:00 PM. He is working with the Pastor, Dr (b) (6) . The party will take place in the Trump Hotel in Washington. It will be televised and Fox's Hannity will attend and we would like the President to attend.

<Ike dinner w Jared 040817.docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 3:20:47 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Document #1 - REMINDERS FOR DINNER WITH JARED KUSHNER - Saturday, April 8th at 7:30 PM
Attachments: Ike dinner w Jared 040817.docx; Untitled attachment 05477.htm

Omg

Sent from my iPhone

Begin forwarded message:

From: "IP" <(b) (6) frenchangel59.com>
Date: April 8, 2017 at 11:02:47 AM EDT
To: "David shulkin" <drshulkin@aol.com>
Subject: Document #1 - REMINDERS FOR DINNER WITH JARED KUSHNER - Saturday, April 8th at 7:30 PM

See attached. I will call you later today.

MEMORANDUM

TO: JARED KUSHNER
FROM: IKE PERLMUTTER
SUBJECT: TOPICS/INITIATIVES FOR DISCUSSION
DATE: APRIL 8, 2017
CC:

PHYSICAL INFRASTRUCTURE

1. <!--[if !supportLists]--><!--[endif]-->Concentrate on the 30% good hospitals the VA currently has
2. <!--[if !supportLists]--><!--[endif]-->Approximately 700 vacant and underutilized locations –
    a. <!--[if !supportLists]--><!--[endif]-->Sell right away - the VA must be permitted to utilize the cash for better use.
    b. <!--[if !supportLists]--><!--[endif]-->Let a third party run/manage homeless shelters. They will do a better job.
    c. <!--[if !supportLists]--><!--[endif]-->Do not use the real estate to build more Homeless shelters.

INFORMATION TECHNOLOGY

3. <!--[if !supportLists]--><!--[endif]-->The CIO from Mayo Clinic is overseeing (and other institutions are participating in) a search for a new CIO for the Dept. of Veterans

AMERICAN OVERSIGHT

Affairs. CIO candidates will be in DC on April 17th for interviews by the VA, Mayo's CIO and others.

STAFFING

4. <!--[if !supportLists]--><!--[endif]-->Freeze "All Hiring" – Not only with the Secretary of the VA but throughout all agencies and departments. Hiring should be done on a case by case basis and only upon the Secretary's approval.
5. <!--[if !supportLists]--><!--[endif]-->Institute an early retirement employee buyout program.
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BUDGETING

7. <!--[if !supportLists]--><!--[endif]-->The FY17 VA budget is over $181 Billion. We are evaluating the budget to identify waste, inefficiencies and potential surpluses.
8. <!--[if !supportLists]--><!--[endif]-->The preliminary goal looks like a potential minimum reduction of $15B.
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PTSD | SUICIDE PREVENTION

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INFORMATION TECH | ELECTRONIC MEDICAL RECORDS SYSTEM

12. <!--[if !supportLists]--><!--[endif]-->DOD recently signed a new contract to implement a new system (Cerner) with an initial cost of $4.3 billion and a total budgeted cost of $9 billion. **There is a push for the VA to choose the same Cerner system.**
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AMERICAN OVERSIGHT

d. <!--[if !supportLists]--><!--[endif]-->Cerner's DOD implementation then MUST be instructed talk to whatever system the VA chooses to install.

WHITE HOUSE LIAISON

14. <!--[if !supportLists]--><!--[endif]-->The VA transformation process is moving quickly and effectively by leaning on the expertise of the team I assembled (hospital, medical and restructuring experts). The effort is more efficiently and effectively managed as a unified, singular effort. To be most efficient (and successful) the White House staff would contribute best if focused on opening doors and removing political obstacles, when requested, but not on overseeing their own initiatives. Currently, our group doesn't need to inconvenience (b) (6) (b) (6) and her group, but needs them available (on call) when requested. For our continuing needs, we can interface with (b) (6) which will also develop him as an operator in business as well.

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/8/2017 7:32:21 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Definitely much much better;

1) is there a way of making it into only 5- with maybe combining transparency with the Greater Choice.

2) Also, there has to be a strong "accountability" priority - maybe adding it to the "efficient use of resources".

3) Does Fraud/waste/abuse message have to be explicit or is it implicit in that Priority of efficient use of resources?

Sent from my iPhone

On Apr 8, 2017, at 3:02 PM, David Shulkin <drshulkin@aol.com> wrote:

> Do you like this any better than the 10 priorities?- I got it to 6
>
> <priorities.pptx>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/8/2017 7:02:50 PM
To: (b) (6) hotmail.com
Attachments: priorities.pptx

Do you like this any better than the 10 priorities?- I got it to 6

AMERICAN OVERSIGHT

The Secretary's 6 Priorities

- Greater Choice to Veterans
  - -Revise the 40/30 Rule
  - -Build an Integrated Network of Care
- Modernize our System
  - -Infrastructure Improvements and Consolidations
  - -EMR Interoperability and Modernization
- Focus Resources More Efficiently
  - -Foundational Services in VA
  - -VA/DOD/Community Coordination
- Suicide Prevention
- Improve Timeliness of Services
  - - Wait times and Accessibility for Care
  - - Decisions on Appeals
  - - Performance on Disability Claims
- Deliver on Accountability and Transparency

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/18/2017 2:34:44 AM
To: (b) (6) [(b) (6) gmail.com]

Can we ask the librarian to get a full copy

http://annals.org/aim/article/2621651/understanding-veteran-wait-times

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 7:40:03 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]
Subject: Prep for your meetings

Ike- sorry I think i missed your call and did not reach you when I tried back just now

I sent you the one executive order

We did get the Choice extension through the Senate and the House this week and it will be ready for the Presidents signature when he returns to DC

We are working on two big things. First as you know we may be able to get VA and the Department of Defense on the same IT platform- if we did this it would both lives and money

Second we are working to eliminate the 40 mile rule soon and give veterans much greater choice. In order to do this we need the Presidents help in the budget in years 2019-21 (we are ok in 2018). In 2019 we need to keep our current budget and then use savings we find in our mandatory spending to keep for greater choice for veterans. If we dont do this then we need new funds and I dont want to ask for any new money. In years 2020-21 I think we will be in better shape as we will realize savings from facility closures but it will take us 1-2 years to get these done.

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/12/2017 9:24:23 PM
To: David Shulkin [drshulkin@aol.com]

https://www.usatoday.com/story/news/politics/2017/04/12/veterans-danger-va-hospital-washington-dc-investigation-finds/100376124/

Your pictures are at the bottom.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 10:27:50 PM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: Decision Memo for President

Great

Sent from my iPhone

> On Apr 7, 2017, at 6:26 PM, Darin Selnick <(b) (6) k@gmail.com> wrote:
>
> FYI
>
> (b) (6) just sent me a draft decision memorandum she made up for the President to sign for the Veterans Choice Improvement Act. Her ask was for me to review and edit, which I did. A couple of sentences needed to be reworked so that they would be more accurate, and I sent it back to her with the corrections.
>
> Hopefully this means it gets signed very soon.
>
> Darin
>
>

AMERICAN OVERSIGHT

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From: Darin Selnick [(b) (6) @gmail.com]
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Hopefully this means it gets signed very soon.

Darin

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/25/2017 4:57:58 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]

Senator issakson cannot make the dinner since its the same night as the senate spouses dinber- he apologizes

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:22:33 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: (No Subject)

Print

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) torreyapartners.com>
Date: April 6, 2017 at 7:21:09 AM EDT
To: David shulkin <Drshulkin@aol.com>
Subject: Re: (No Subject)

Some things below don't make much sense below. Don't all patients in all IRBs have the central privacy review and I assume information security review is also standard or could be added.

I disagree with the lack of benefits to the vets. They get intense state of the art monitoring and the latest advances. In fact, in oncology, the FDA allows phaseless design -- the phase 1 goes right to phase 2 and phase 3. Its seamless---there is a concept that if a patient responds then its a n of one trial.

The IP issue does not make sense in an industry trial. Maybe they mean who can publish? Industry owns the data but must release it.

Here is my suggestion to save you the most valuable asset you have -- your time. There are 2 options. One, I learned from a ceo who bought 15 biotech companies. Ask your team---how could we set up a phase 1 unit with central IRB and one master contract. The biotech ceo would tell his team, I know all the reasons why we should not buy x, I want to hear why we should do it and how we do it.

Or the second is i can take these concerns/issues orally (won't ever send an email from you or your people without your explicit approval) to jim greenwood of bio.

He would appoint a group and once they have flushed out the issues and can step up then we have a meeting like we had on Monday with regeneron but there needs to be prep to get these ironed out.

The win here beyond better care/options for vets is the industry does not to go to china. Someone may like that.

Last point--The one call you should make is to rob califf. He knows the IRB issues and other obstacles. His big issue is the govt (Medicare and medicaid) can't pay for clinical trials--he is correct but smaller companies and the big pharma don't want to go to china/overseas and they are

AMERICAN OVERSIGHT

glad to pay here in the US. The logistics of flying over to china and other countries and monitoring overseas is a pain.

On Apr 5, 2017, at 11:18 PM, David shulkin <Drshulkin@aol.com> wrote:

When you get tine- let me know your thoughts

Sent from my iPhone

Begin forwarded message:

-----Original Message-----
From: Ramoni, Rachel
Sent: Wednesday, April 05, 2017 09:00 PM Eastern Standard Time
To: DJS
Cc: Alaigh, Poonam, M.D.; Lee, Jennifer S. (VACO)
Subject: RE:

Dear Dr. Shulkin,

I met with my team at ORD today -- responses follow:

- Feedback from industry is that we need a truly functional central irb -- The VA central IRB currently has 200 VA studies and 5 industry trials open. Until recently, the VA central IRB was not allowed to do industry trials. Since that restriction was lifted, 5 industry studies were approved. At present, an agreement to allow industry to reimburse the central IRB for review is awaiting Carolyn Clancy's approval -- charging industry for such review is the norm. Our central IRB includes central privacy and information security review, necessary steps that would not be offered by a commercial IRB. We would be very interested to hear the specific criticisms from industry.

We should look at NCAts from NIH as a model -- I have a meeting scheduled with Chris Adams, the head of NCATS.

We should look at phase 1 units- do we have any currently? -- We can respond better if we understand the motivation for increased phase I trials. In the past, participation in such trials was discouraged because of the higher risk to Veterans and the lower potential for benefits. The current Master CRADA templates do not offer any advantage IP-wise for phase I trials (we currently do not get any IP for phase I - IV trials under the master CRADA template).

Is there already a group looking at clinical trials? Yes, we are in the process of executing an agreement with NCI to both increase the number of NCI trials available to our Veterans and to make the process more efficient. NCI is going to fund this effort. We would be very happy to have industry perspectives as we modernize our clinical trials process.

Novartis has a platform they would give us called signature platform -- I will alert Mike Kelley (an oncologist at the Durham who is involved in the NCI trials project as well as the APOLLO effort) to this, as it seems like the signature platform has to do with matching patients to therapy based upon their genomic

AMERICAN OVERSIGHT

profile. Is there a point of contact at Novartis?

Do you have plans underway? Yes -- with NCI. We'd like to add in multiple industry perspectives, including smaller industry perspectives, given the more limited marketplace for some Veteran-specific conditions. We anticipate that there will be a number of considerations as we expand industry trials at the VA, including the potential impact on access of shifting clinician time to clinical trials, so this is an effort that will touch a number of points at VHA.

When will you present your strategy for research? We are having a strategic planning meeting on April 12. A first draft of our strategy will be distributed for input at the end of April.

With appreciation,

Rachel

-----Original Message-----
From: DJS
Sent: Wednesday, April 05, 2017 7:29 AM
To: Ramoni, Rachel
Cc: Alaigh, Poonam, M.D.
Subject:
Importance: High

Rachel- as you know with our Johnson and Johnson meetings we set as a goal to increase clinical trials

Feedback from industry is that we need a truly functional central irb

We should look at NCAts from NIH as a model

We should look at phase 1 units- do we have any currently?

Is there already a group looking at clinical trials?

Novartis has a platform they would give us called signature platform

Do you have plans underway?

When will you present your strategy for research?

Sent with Good (www.good.com)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 3:20:51 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: (No Subject)

Print

Sent from my iPhone

Begin forwarded message:

From: DJS <vacodjs1@va.gov>
Date: April 5, 2017 at 11:10:19 PM EDT
To: 'Shulkin ' <drshulkin@aol.com>
Subject: FW: (No Subject)

Sent with Good (www.good.com)

-----Original Message-----
From: Ramoni, Rachel
Sent: Wednesday, April 05, 2017 09:00 PM Eastern Standard Time
To: DJS
Cc: Alaigh, Poonam, M.D.; Lee, Jennifer S. (VACO)
Subject: RE:

Dear Dr. Shulkin,

I met with my team at ORD today -- responses follow:

- Feedback from industry is that we need a truly functional central irb -- The VA central IRB currently has 200 VA studies and 5 industry trials open. Until recently, the VA central IRB was not allowed to do industry trials. Since that restriction was lifted, 5 industry studies were approved. At present, an agreement to allow industry to reimburse the central IRB for review is awaiting Carolyn Clancy's approval -- charging industry for such review is the norm. Our central IRB includes central privacy and information security review, necessary steps that would not be offered by a commercial IRB. We would be very interested to hear the specific criticisms from industry.

We should look at NCAts from NIH as a model -- I have a meeting scheduled with Chris Adams, the head of NCATS.

We should look at phase 1 units- do we have any currently? -- We can respond better if we understand the motivation for increased phase I trials. In the past, participation in such trials was discouraged because of the higher risk to Veterans and the lower potential for benefits. The current Master CRADA templates do not offer any advantage IP-wise for phase I trials (we currently do not get any IP for phase I - IV trials under the master CRADA template).

Is there already a group looking at clinical trials? Yes, we are in the process of executing an agreement with NCI to both increase the number of NCI trials available to our Veterans and to make the process more efficient. NCI is going to fund this effort. We would be very happy to have industry perspectives as we modernize our clinical trials process.

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Novartis has a platform they would give us called signature platform -- I will alert Mike Kelley (an oncologist at the Durham who is involved in the NCI trials project as well as the APOLLO effort) to this, as it seems like the signature platform has to do with matching patients to therapy based upon their genomic profile. Is there a point of contact at Novartis?

Do you have plans underway? Yes -- with NCI. We'd like to add in multiple industry perspectives, including smaller industry perspectives, given the more limited marketplace for some Veteran-specific conditions. We anticipate that there will be a number of considerations as we expand industry trials at the VA, including the potential impact on access of shifting clinician time to clinical trials, so this is an effort that will touch a number of points at VHA.

When will you present your strategy for research? We are having a strategic planning meeting on April 12. A first draft of our strategy will be distributed for input at the end of April.

With appreciation.

Rachel

-----Original Message-----
From: DJS
Sent: Wednesday, April 05, 2017 7:29 AM
To: Ramoni, Rachel
Cc: Alaigh, Poonam, M.D.
Subject:
Importance: High

Rachel- as you know with our Johnson and Johnson meetings we set as a goal to increase clinical trials

Feedback from industry is that we need a truly functional central irb

We should look at NCAts from NIH as a model

We should look at phase 1 units- do we have any currently?

Is there already a group looking at clinical trials?

Novartis has a platform they would give us called signature platform

Do you have plans underway?

When will you present your strategy for research?

Sent with Good (www.good.com)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:32:48 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Hopkins

Should we connect him to neil in telehealth?

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** April 6, 2017 at 7:21:34 AM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Cc:** (b) (6) hotmail.com
> **Subject: Re: Hopkins**
>
> I am ready anytime.
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> Sent from my iPad
> Bruce Moskowitz M.D.
>
> > On Apr 6, 2017, at 7:18 AM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > We can connect with our Telehealth group when you are ready
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> > Sent from my iPhone
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> > > On Apr 6, 2017, at 6:53 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
> > >
> > > I spoke to this group at Hopkins and told them I would discuss a pilot project on their nickel! Actually they have an impressive record so far.
> > >
> > > <emocha Letter to Dr Moskowitz 04052017.pdf>
> > >
> > > Sent from my iPad
> > > Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/6/2017 11:21:34 AM
To: David shulkin [Drshulkin@aol.com]
CC: (b) (6) hotmail.com
Subject: Re: Hopkins

I am ready anytime.

Sent from my iPad
Bruce Moskowitz M.D.

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>>
>> <emocha Letter to Dr Moskowitz 04052017.pdf>
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>> Sent from my iPad
>> Bruce Moskowitz M.D.
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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:18:24 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: (b) (6) hotmail.com
Subject: Re: Hopkins

We can connect with our Telehealth group when you are ready

Sent from my iPhone

> On Apr 6, 2017, at 6:53 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
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> I spoke to this group at Hopkins and told them I would discuss a pilot project on their nickel! Actually they have an impressive record so far.
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> <emocha Letter to Dr Moskowitz 04052017.pdf>
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> Sent from my iPad
> Bruce Moskowitz M.D.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/6/2017 10:53:27 AM
To: drshulkin@aol.com; (b) (6) hotmail.com
Subject: Hopkins
Attachments: emocha Letter to Dr Moskowitz 04052017.pdf; Untitled attachment 05592.txt

I spoke to this group at Hopkins and told them I would discuss a pilot project on their nickel! Actually they have an impressive record so far.

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emocha®
MOBILE HEALTH INC

April 5, 2017

Dr. Bruce Moskowitz
BY EMAIL

Re: Video-based Directly Observed Therapy (DOT) for Opioid Addiction Treatment; pilot with the VA

Dear Dr. Moskowitz,

Many thanks for our conversation yesterday. We are a mobile technology company that spun out of Johns Hopkins School of Medicine in 2013. Our modular, HIPAA-compliant platform is specialized in securing medication adherence and keeping patients linked to care. In addition to having developed a world-class, proven product, our affiliation with Johns Hopkins University has been a key factor in our success. We have had the great fortune of developing our software with public health experts in HIV, hepatitis C, tuberculosis (TB), and opioid addiction through our close connection to academia.

Our asynchronous solution is a novel and efficient form of telehealth focused on medication adherence, using a video recording rather than live stream connection to achieve adherence rates typically above 90%. The platform has been most frequently deployed to monitor TB therapy as DOT is the accepted standard of care. emocha has been implemented in more than twenty-five clinics all over the country, as well as in Australia and India. Our NIH-funded study for implementing the technology among TB patients in Maryland has demonstrated rates of medication adherence comparable to the high rates of in-person DOT, while creating significant savings for health departments. Furthermore, qualitative interviews with staff and patients showed a high level of acceptability. We have also recently deployed our video DOT solution in nine clinics nationwide for monitoring adherence to 12-week, single dose HCV regimens among injection drug using patients.

We have received a Notice of Intent to Fund a SBIR grant from NIDA to support our efforts in opioid addiction. **We believe that our asynchronous video-based DOT solution can provide a strong support and monitoring system for patients being treated for opioid addiction using office-based therapies** such as take-home buprenorphine while serving as an automated triage tool for providers. Patients use a smartphone or tablet to report side effects or cravings, view their regimen, and video record themselves taking their medication at every dose. On a secure web portal, the provider or a case manager reviews the video to assess adherence soon after the data is submitted. Using sophisticated protocols and algorithms, the provider is guided to efficiently and selectively engage patients who need support in order to keep them on track. Our NIDA-funded work involves pilot testing at office-based buprenorphine programs run by University of Washington in Seattle and Boston University. Dr. (b) (6) [redacted],

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the Director for the substance abuse program at the VA Puget Sound Health Care System, is part of the project team.

Helping veterans struggling with opioid addiction is one of the highest priorities for the VA, and **we propose to use emocha in a pilot with a VA clinic, potentially as part of our NIDA project**. We propose implementing the technology for patients entering their buprenorphine initiation phase. Patients will receive the application from their provider who will utilize the application to monitor their adherence for the first 3-6 months after initiation of buprenorphine treatment—a period when patients are at high risk to dropout and relapse to illicit opiate use. The application can also be used at later stages if a patient is struggling to maintain abstinence or if the provider has concerns regarding diversion. The application will also include educational materials, appointment reminders, tailored, dynamic messaging to assuage cravings, and risk assessments to prioritize provider intervention. Video capture will also allow providers to visualize their patients and their environment each day. We believe this has the potential to increase adherence, provide patient-centered social support at scale, track outcomes over time, as well as serve as a powerful diversion mitigation strategy.. We believe partnering with a VA medical center would be an ideal setting to implement the technology.

emocha video DOT could also be expanded to uses outside of buprenorphine. Patients with other substance abuse or mental health issues could benefit from daily support in the proper taking of their medications. In other cases, patients in remote areas with limited internet connectivity could remain engaged with their provider, and helped to achieve high levels of adherence.

We would appreciate any advice you may have and we look forward to further conversations. Many thanks in advance for your support.

Sincerely,

(b) (6) [redacted]

CEO

(b) (6) [redacted]@emocha.com
(410) 804-(b) (6) [redacted]

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Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/7/2017 9:31:02 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]; Marc Sherman [(b) (6) gmail.com]
Subject: Re: Information systems article

Excellent and goes right after what we want including a device registry.

Sent from my iPad
Bruce Moskowitz M.D.

On Apr 7, 2017, at 4:27 PM, David shulkin <Drshulkin@aol.com> wrote:

> https://www.meritalk.com/the-situation-report-is-the-cio-job-at-va-about-to-lose-its-influence/
>
> Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 8:27:34 PM
To: Bruce Moskowitz [(b) (6) mac.com]; Ike Perlmutter [(b) (6) frenchangel59.com]; Marc Sherman [(b) (6) gmail.com]
Subject: Information systems article

https://www.meritalk.com/the-situation-report-is-the-cio-job-at-va-about-to-lose-its-influence/

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 11:35:49 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: IP [(b) (6) frenchangel59.com]; mbs(b) (6) @gmail.com
Subject: Re: Pentagon revises schedule for electronic health record rollout

Understood

Sent from my iPhone

> On Apr 5, 2017, at 6:42 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> As the Penn Professor article predicted the roll out is at one hospital system and the delays and costs will increase.
> The bigger problem is that there will be no integration with the majority of community and academic centers medical records. The reason why all 5 of our partners chose Epic independently was discussed by Dr. (b) (6) at our first meeting with the President. I personally do not use Epic but a program designed by Quest Labs that integrates with other internal medicine practices.
> http://federalnewsradio.com/defense/2016/10/pentagon-revises-schedule-electronic-health-record-rollout-including-several-months-delays/
>
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> Sent from my iPad
> Bruce Moskowitz M.D.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/5/2017 10:42:18 AM
To: drshulkin@aol.com
CC: IP [(b) (6) frenchangel59.com]; mbs(b) (6) @gmail.com
Subject: Pentagon revises schedule for electronic health record rollout

As the Penn Professor article predicted the roll out is at one hospital system and the delays and costs will increase.
The bigger problem is that there will be no integration with the majority of community and academic centers medical records. The reason why all 5 of our partners chose Epic independently was discussed by Dr. (b) (6) at our first meeting with the President. I personally do not use Epic but a program designed by Quest Labs that integrates with other internal medicine practices.
http://federalnewsradio.com/defense/2016/10/pentagon-revises-schedule-electronic-health-record-rollout-including-several-months-delays/

Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 12:20:09 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: Proposed Article in Gladwyne Living

Can you get a high resolution photo to bob below?

From: Bob Norkus N2 <bob.norkus@n2pub.com>
Date: April 4, 2017 at 8:57:44 AM EDT
To: (b) (6) <(b) (6) hotmail.com>
Subject: Re: Proposed Article in Gladwyne Living

can you source us to high resolution photos? 300dpi Bo b

On Apr 4, 2017, at 7:50 AM, (b) (6) <(b) (6) hotmail.com> wrote:

Bob, there are several factual errors. Ok for me to correct

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them and ill resend tomorrow?

Sent from my iPhone

On Apr 3, 2017, at 2:01 PM, Bob Norkus N2 <bob.norkus@n2pub.com> wrote:

> Looking forward to hearing fro

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David Shulkin: America's Doctor

On February 13, 2017, longt

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appointedtwoyearsearlierbythenpresidentBarackObama.

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When he announced the nomination, President Trump stated the

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following: "Dr. Shulkin is an incredibly gifted doctor who is

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using his elite talents for medicine to care for our heroes.”

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quoteby David in a May 9, 2016 article in the *Philadelphia Inqu*

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entirely fitting, therefore, that David Shulkin was born on a

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U.S.armybase--FortSheridaninHighlandPark,Illinois--o

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College of Medicine. He completed his internship at the Yale S

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e, Dr. (b) (6) [redacted], a dermatologist who maintains a practice h

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ereinGladwyne.Davidallsoestablishedaprivatepracticein

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Gladwyn easa family doctor.

In 2003, as mentioned above, he

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executive positions and as president of the Morris Town Medica

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l Center. Under his leadership, this facility was named “thes

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D a v i d h a s a l s

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obeenthechiefmedicalofficeratthe
UniversityofPennsylv

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a n i a H e a l t h S y s t e m , t h e H o s p i t a l o f t h e U n i v e r s i t y o f P e n n s y l

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vania, Temple University, and the Medical College of Pennsyl

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and professor of medicine at the Albert Einstein College of Me

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dicine. He has written extensively on peer-reviewed journal articl

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esand, in 2008, a book -- *Questions Patients Need to Ask: Getti*

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ngthe Best Healthcare. If this wasn't enough he founded one of

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the first consumer-oriented information services: Doctor Q

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Today, as the head of the Department of Veterans

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over 366 thousand employees, and 1,233 healthcare facilities

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ISHINGallabout? Learnmoreaboutus **HERE**!

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ITES

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www.instagram.com/gladwynelivingg

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Check out one of N2 events . . .

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Top 20 Private Media Company in the US by INC Magazine for ***SIXYearsinarow..*** *and Ame*

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r i c a ' s l e a d i n g p r o v i d e r o f s p e c i a l t y p u b l i c a t i o n s f o r o v e r 5 0 0 e x c l u s i v e c o m m u n

AMERICAN OVERSIGHT

i t i e s a c r o s s t h e n a t i o n .

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<Paste dGraph ic-1.tiff>

Regards,

Bob

484-354-0287

What is N2 PUBLISHING all about?
Learn more about us **HERE**!

PLEASE VISIT THESE WEB SITES

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<PastedGraphic-1.tiff>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 1:05:22 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: (b) (6) documents
Attachments: (b) (6) CV (2017).doc; Untitled attachment 05659.htm; (b) (6) (2.16.2017).docx; Untitled attachment 05662.htm; Executive Profile (b) (6) (11.28.2016).docx; Untitled attachment 05665.htm

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) gmail.com>
Date: April 5, 2017 at 6:37:40 AM EDT
To: drshulkin@aol.com
Subject: (b) (6) **documents**

As discussed, please see attached. Thanks again Dr. Shulkin!

(b) (6)

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(b) (6), (b) (2)
(b) (6), (b) (2), Pennington, NJ (b) (6), (b) (2)
(b) (6), (b) (2) (b) (6), (b) (2)@verizon.net

PROFILE

(b) (6), (b) (2)
.

EXPERIENCE

(b) (6), (b) (2) 2011-2016

(b) (6), (b) (2)

- .

(b) (6), (b) (2) (2015-2016)
(b) (6), (b) (2)

(b) (6), (b) (2) (2011-2015)
(b) (6), (b) (2)

(b) (6), (b) (2) 2008-2011

(b) (6), (b) (2)

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- (b) (6), (b) (2)

(b) (6), (b) (2) 1998-2008

(b) (6), (b) (2)

1986-1998

(b) (6), (b) (2)

(1991-1994)
(b) (6), (b) (2)

(1986-1991)
(b) (6), (b) (2)
.

(b) (6), (b) (2) 1984-1985

(b) (6), (b) (2)

1982-1983

(b) (6), (b) (2)

EDUCATION

(b) (6), (b) (2) 1982
1978

PUBLIC SERVICE

(b) (6), (b) (2) 1997-2008
(b) (6), (b) (2)

(b) (6), (b) (2) 1999-2007
(b) (6), (b) (2)

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(b) (6)
(b) (6), (b) (2)
Pennington, NJ (b) (6), (b) (2)
609.462.(b) (6), (b) (2)
(b) (6), (b) (2) @verizon.net

To Whom It May Concern:

(b) (6), (b) (2)

I would welcome the opportunity to discuss my professional interests with you at your convenience. I can be reached at 609.462.(b) (6), (b) (2) (cell) or (b) (6), (b) (2) @verizon.net.

Thank you, and best regards.

Very truly yours,

(b) (6)

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[redacted]

609.462.[redacted] [redacted]@verizon.net

Profile

[redacted]

Key Skills

- [redacted]

Major Accomplishments

- [redacted]

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Appointment

From: Marisol Garcia [(b) (6) frenchangel59.com]
Sent: 4/4/2017 11:36:45 PM
To: (b) (6) its.jnj.com; ktorok1@its.jnj.com; 'David shulkin' [Drshulkin@aol.com]; 'L Perl' [(b) (6) gmail.com]; 'Bruce Moskowitz' [(b) (6) mac.com]; mbs(b) (6) @gmail.com; (b) (6) frenchangel59.com; (b) (6) va.gov; (b) (6) va.gov; (b) (6) (b) (6) [(b) (6) mayo.edu]; (b) (6) [(b) (6) mayo.edu]; (b) (6) [JJCUS]' [(b) (6) ts.jnj.com]; (b) (6) [JSGUS]' [(b) (6) its.jnj.com]; (b) (6) [JRDUS]' [(b) (6) its.jnj.com]; (b) (6) Bruce Moskowitz,MD' [(b) (6) gmail.com]; (b) (6) [(b) (6) va.gov]

Subject: Conference Call with (b) (6) (Johnson and Johnson) and Ike Perlmutter and their teams - Monday, April 17, 2017 at 2:00 PM EST (30 minutes)
Location: Conference Call

Start: 4/17/2017 6:00:00 PM
End: 4/17/2017 6:30:00 PM
Show Time As: Tentative

Recurrence: (none)

Monday, April 17th

2:00 PM – 2:30 PM EST

Dial-in Information:

US: 1-866-244-(b) (6)

International: 719-457-(b) (6)

Passcode: (b) (6)

Participants:

(b) (6) Chairman and CEO (Johnson & Johnson), (b) (6) (b) (6) and Dr. (b) (6) Secretary David Shulkin (White House), Dr.

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Bruce Moskowitz, Marc Sherman, [redacted] (Chair, Mayo Clinic) and Ike

Thank you,

Marisol Garcia

(646) 201-[redacted] (Cell)

[redacted] frenchangel59.com

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 10:04:32 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: CIO

I see two from Yale and 2 from Florida. I dont see a hopkins one

Sent from my iPhone

> On Apr 7, 2017, at 5:40 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> No go ahead we have 5 now including the one from Hopkins. All excellent I can get more
>
> Sent from my iPhone
>
>> On Apr 7, 2017, at 5:26 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Bruce- thanks for the four CVs for CIO.
>> Is it okay to contact them yet or do you want yo have discussions with them first?
>>
>> David
>>
>> Sent from my iPhone
>>
>>> On Apr 7, 2017, at 3:31 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
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>>> <(b) (6) Resume Mar 2017.docx>
>>>
>>>
>>>
>>> Sent from my iPad
>>> Bruce Moskowitz M.D.
>>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 10:02:42 PM
To: Va David [vacodjs1@va.gov]
Subject: Fwd: CIO
Attachments: 2017 March 2 (b) (6) CV.docx; Untitled attachment 05680.htm

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** April 7, 2017 at 3:29:55 PM EDT
> **To:** drshulkin@aol.com
> **Subject: CIO**
>
> U of Fl

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CURRICULUM VITAE{PRIVATE }

Name: [redacted]
Department: [redacted]
[redacted] *Health* [redacted]
Present Rank: [redacted]
Business Address: [redacted], Gainesville, FL [redacted]
Business Telephone: 352-265-[redacted]
Home Address: [redacted], Gainesville, FL [redacted]

EDUCATIONAL RECORD:

Professional Development

[redacted]

Fellowship:

[redacted]

Residency:

[redacted]

Medical School:

[redacted]

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(b) (6), (b) (2)

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Graduate:

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(b) (6), (b) (2)

Undergraduate:

(b) (6), (b) (2)

983

BOARD CERTIFICATION:

(b) (6), (b) (2)

LICENSURE:

State	Number	Date	Status
(b) (6), (b) (2)			

EMPLOYMENT:

Place of Employment City	Title or Position	Years of Empl.
(b) (6), (b) (2)		

(b) (6), (b) (2)

HONORS AND/OR AWARDS:

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

SERVICE/PATIENT CARE LEADERSHIP:

UNIVERSITY SERVICE:

(b) (6), (b) (2) [redacted]

COLLEGE OF MEDICINE SERVICE

(b) (6), (b) (2) [redacted]

COLLEGE OF MEDICINE, ADMISSIONS:

(b) (6), (b) (2) [redacted]

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COLLEGE OF MEDICINE, OTHER

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(b) (6) COM, SEARCH COMMITTEES

(b) (6), (b) (2)

NATIONAL SERVICE

(b) (6), (b) (2)

COMMUNITY HOSPITAL - PATIENT LEADERSHIP

(b) (6), (b) (2)

(b) (6), (b) (2) HOSPITAL – FACULTY GROUP PRACTICE – (b) (6).

(b) (6), (b) (2)

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

COMMUNITY SERVICE:

(b) (6), (b) (2) [redacted]

GRANT REVIEWS

(b) (6), (b) (2) [redacted]

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

(b) (6), (b) (2) [redacted]

EDUCATIONAL ACTIVITIES:

Curriculum Development

(b) (6), (b) (2) [redacted]

Evaluation Methods/Development

(b) (6), (b) (2) [redacted]

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Family Practice noon conferences series (some old, some still being given)

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Older

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RAST (b) (6), (b) (2)

Preceptorships

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Other Lectures

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(b) (6), (b) (2)

[redacted]

Journal/Publication/Conference Submission Reviews

(b) (6), (b) (2)

[redacted]

PRESENTATIONS:

Invited Presentations, lecture, poster or other, Local, National and International

(b) (6), (b) (2)

[redacted]

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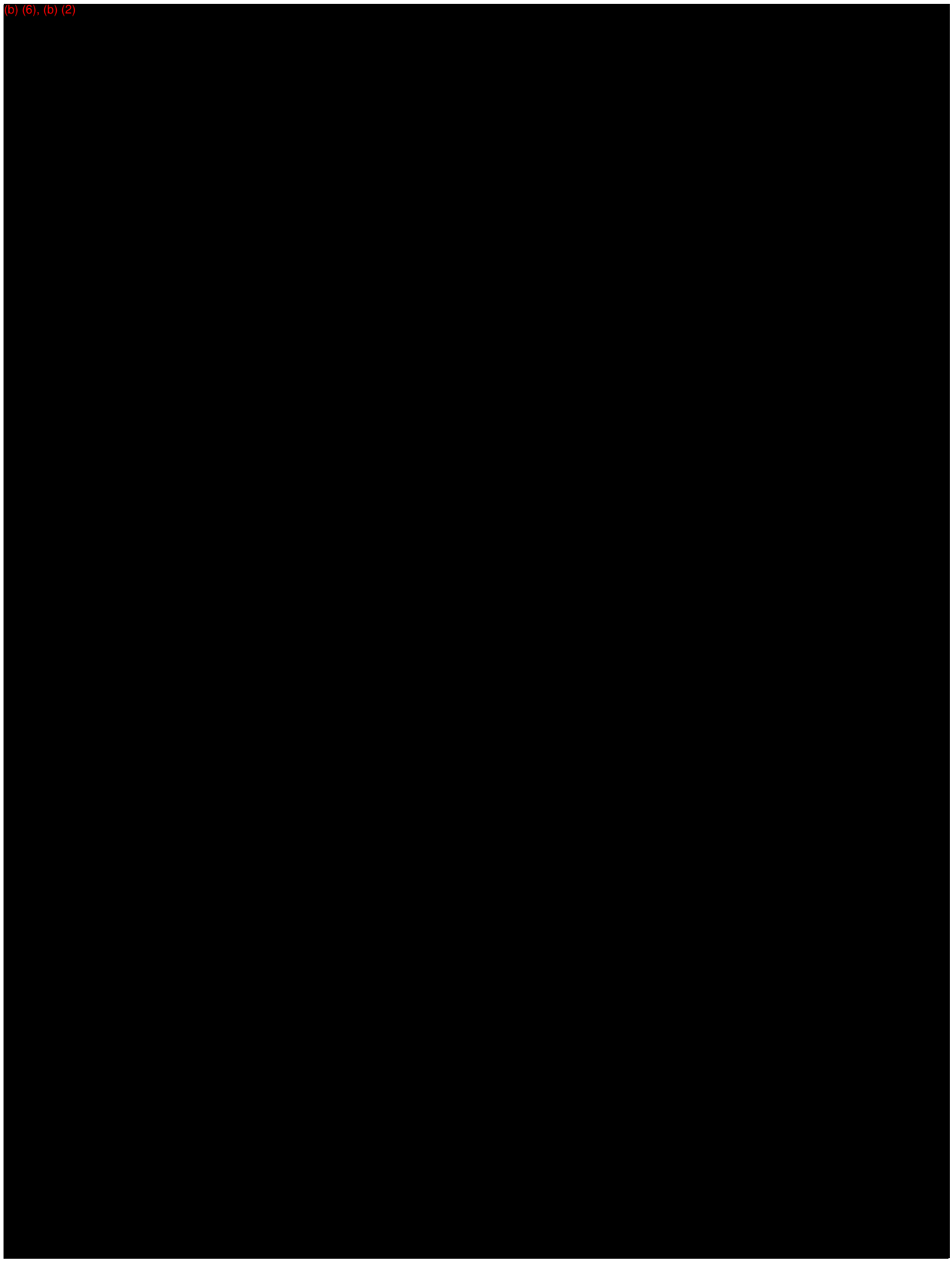

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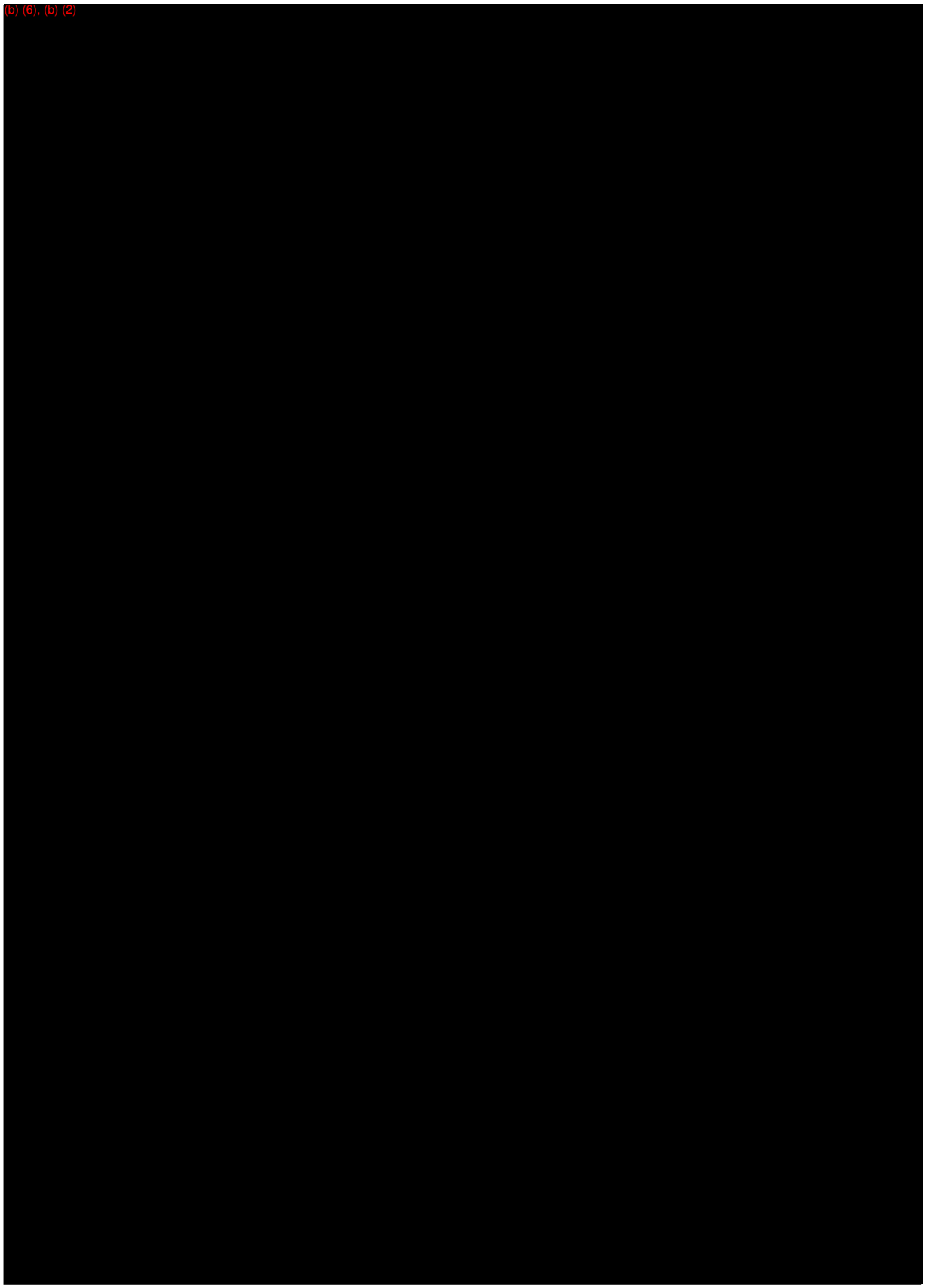

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(b) (6), (b) (2) [redacted]

LOCAL PRESENTATIONS

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CONTRACTS AND GRANTS:

(b) (6), (b) (2) [redacted]

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MAJOR CONSULTATIONS OUTSIDE THE UNIVERSITY:

(b) (6), (b) (2)

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PUBLICATIONS:

Books

Published:

(b) (6), (b) (2)

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(b) (6), (b) (2)

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Refereed Journals

(b) (6), (b) (2)

[redacted]

Non-refereed Publications

(b) (6), (b) (2)

[redacted]

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(b) (6), (b) (2)

[redacted]

Electronic Publications: (These are probably aged to the point that the links no longer work)

(b) (6), (b) (2)

[redacted]

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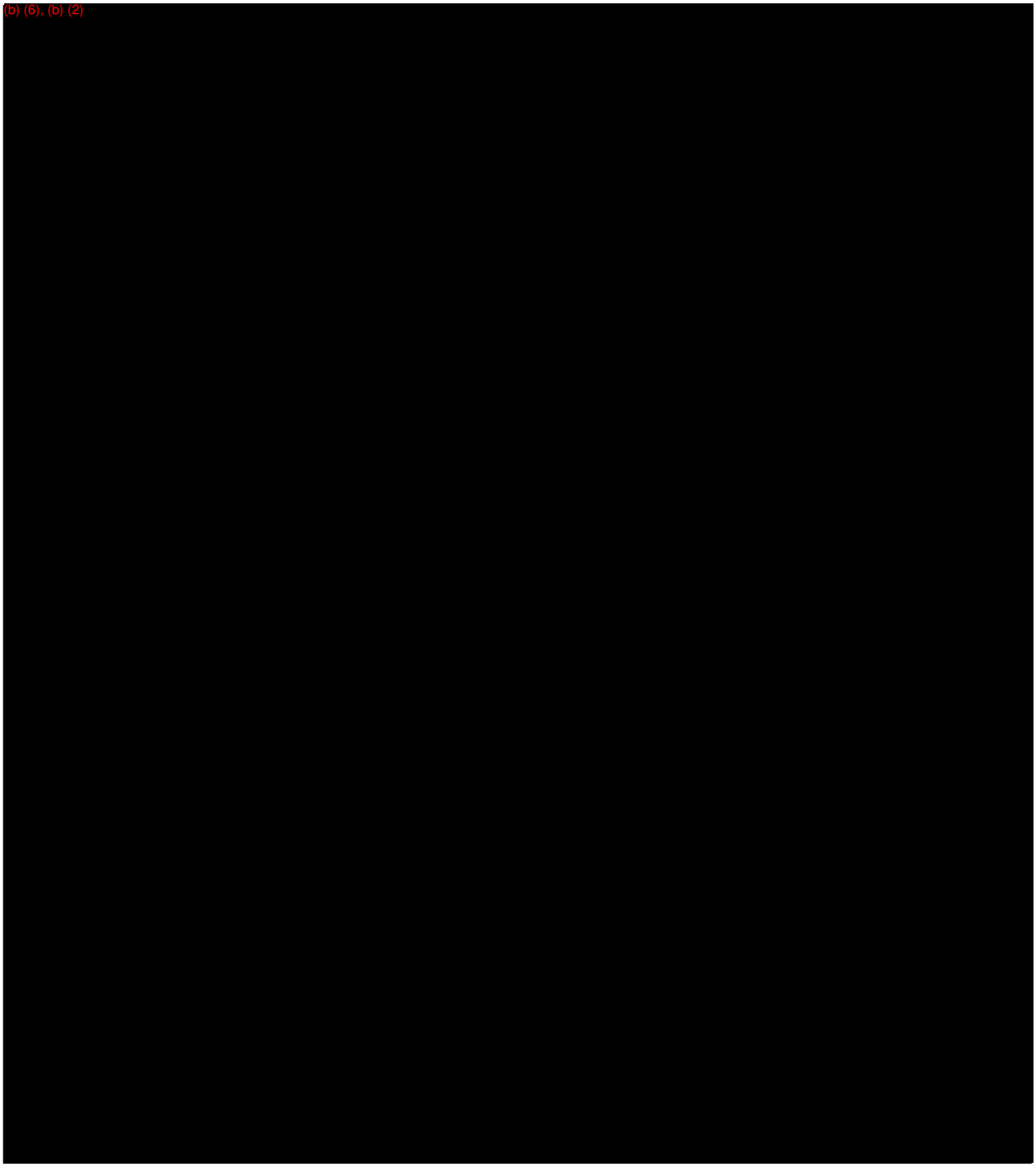

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Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 10:02:31 PM
To: Va David [vacodjs1@va.gov]
Subject: Fwd: CIO
Attachments: 2017 March 2 (b) (6) CV.docx; Untitled attachment 05685.htm

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** April 7, 2017 at 3:29:55 PM EDT
> **To:** drshulkin@aol.com
> **Subject: CIO**
>
> U of Fl

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CURRICULUM VITAE {PRIVATE }

Name: [redacted]
Department: [redacted]
Health [redacted]
Present Rank: [redacted]
Business Address: [redacted], Gainesville, FL [redacted]
Business Telephone: 352-265-[redacted]
Home Address: [redacted], Gainesville, FL [redacted]

EDUCATIONAL RECORD:

Professional Development

[redacted]

Fellowship:

[redacted]

Residency:

[redacted]

Medical School:

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)
[redacted]

(b) (6), (b) (2)
[redacted]

Graduate:

(b) (6), (b) (2)
[redacted]

Undergraduate:

(b) (6), (b) (2)
[redacted]

BOARD CERTIFICATION:

(b) (6), (b) (2)
[redacted]

LICENSURE:

State	Number	Date	Status
(b) (6), (b) (2) [redacted]			

EMPLOYMENT:

Place of Employment City	Title or Position	Years of Empl.
(b) (6), (b) (2) [redacted]		

HONORS AND/OR AWARDS:

(b) (6), (b) (2)
[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

SERVICE/PATIENT CARE LEADERSHIP:

UNIVERSITY SERVICE:

(b) (6), (b) (2)

[redacted]

COLLEGE OF MEDICINE SERVICE

(b) (6), (b) (2)

[redacted]

COLLEGE OF MEDICINE, ADMISSIONS:

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

COLLEGE OF MEDICINE, OTHER

(b) (6), (b) (2)

[redacted]

(b) (6) COM, SEARCH COMMITTEES

(b) (6), (b) (2)

[redacted]

NATIONAL SERVICE

(b) (6), (b) (2)

[redacted]

COMMUNITY HOSPITAL - PATIENT LEADERSHIP

(b) (6), (b) (2)

[redacted]

(b) (6) (b) (6), (b) (2) - (b) (6), (b) (2) HOSPITAL – FACULTY GROUP PRACTICE – [redacted] (b) (6),

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

COMMUNITY SERVICE:

(b) (6), (b) (2) [redacted]

GRANT REVIEWS

(b) (6), (b) (2) [redacted]

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

(b) (6), (b) (2) [redacted]

EDUCATIONAL ACTIVITIES:

Curriculum Development

(b) (6), (b) (2) [redacted]

Evaluation Methods/Development

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

Family Practice noon conferences series (some old, some still being given)

(b) (6), (b) (2) [redacted]

Older

(b) (6), (b) (2) [redacted]

RAST (Resident AS Teachers)

(b) (6), (b) (2) [redacted]

Preceptorships

(b) (6), (b) (2) [redacted]

Other Lectures

[redacted] (b) (6), [redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Journal/Publication/Conference Submission Reviews

(b) (6), (b) (2)

[redacted]

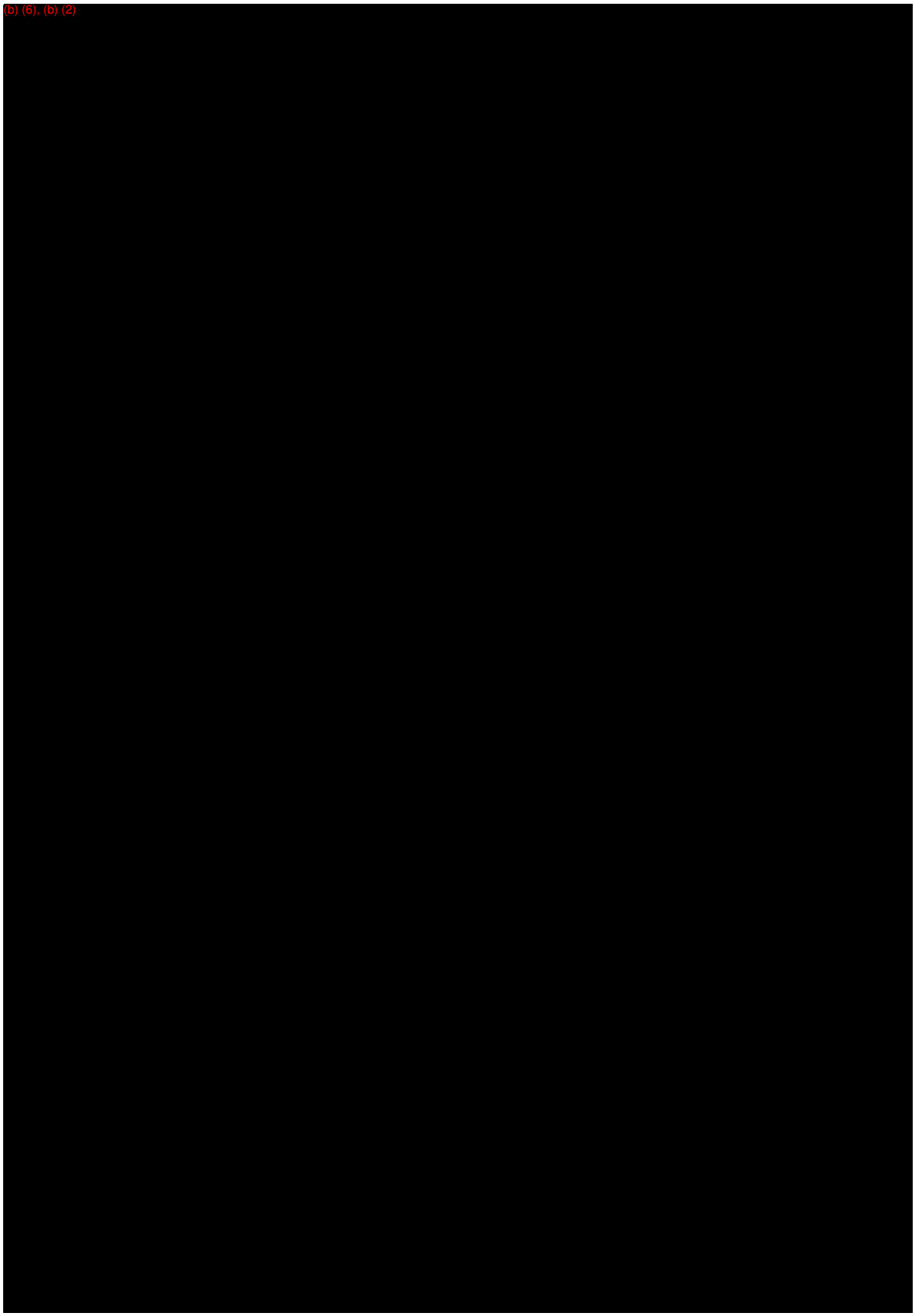
PRESENTATIONS:

Invited Presentations, lecture, poster or other, Local, National and International

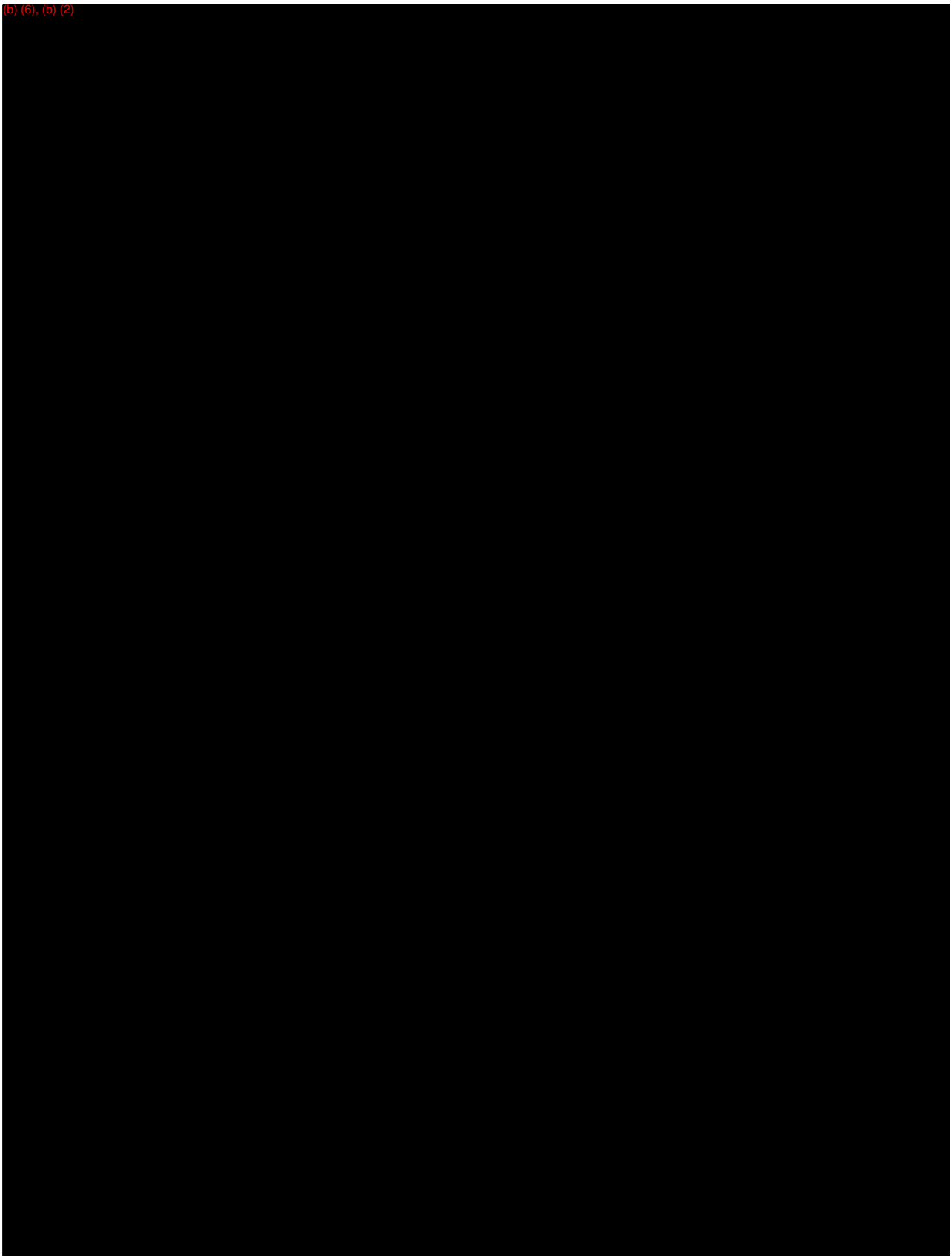
(b) (6), (b) (2)

[redacted]

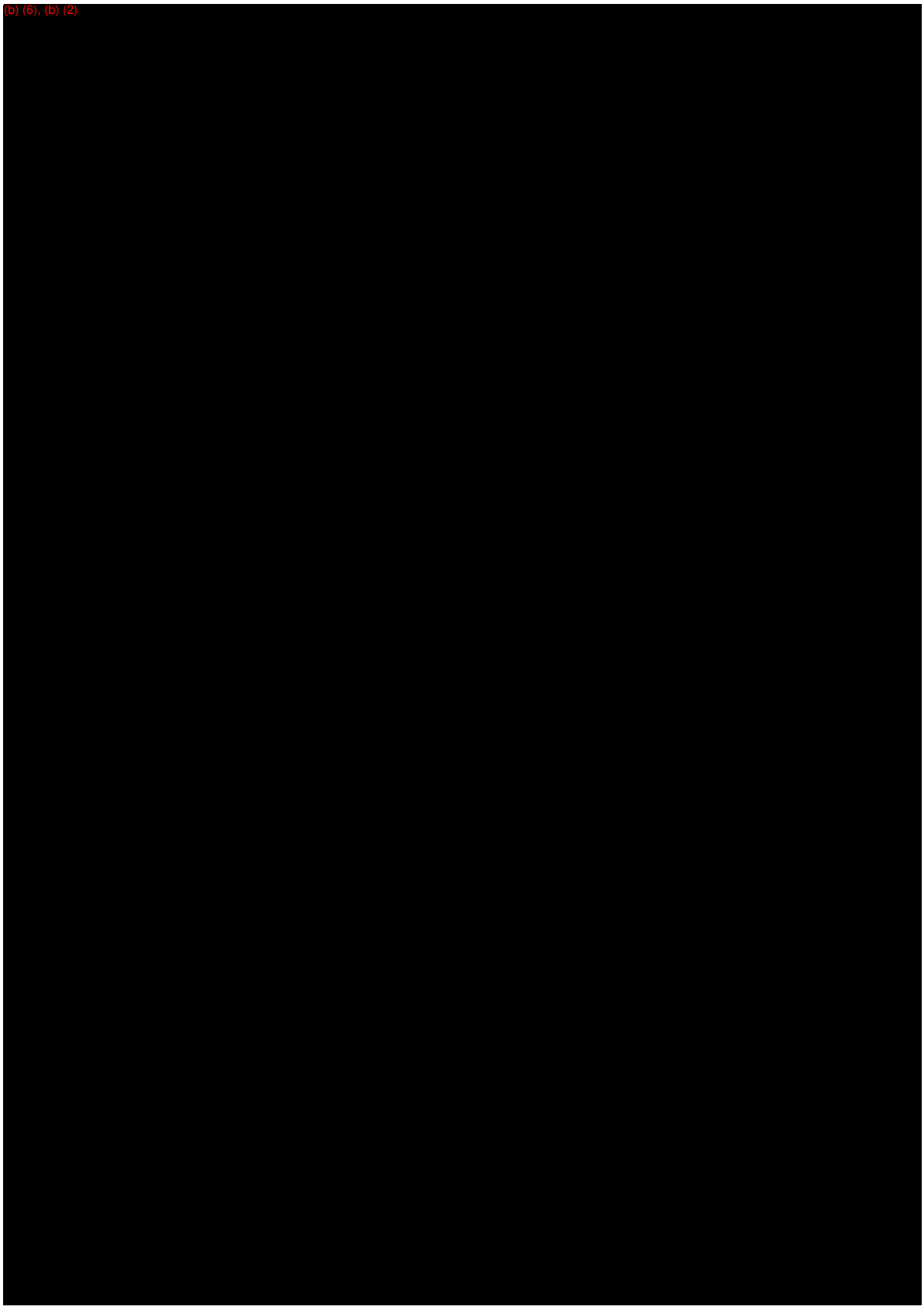
AMERICAN OVERSIGHT



AMERICAN OVERSIGHT



AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

(b) (6), (b) (2) .

LOCAL PRESENTATIONS

(b) (6), (b) (2)

CONTRACTS AND GRANTS:

(b) (6), (b) (2)

AMERICAN OVERSIGHT

MAJOR CONSULTATIONS OUTSIDE THE UNIVERSITY:

(b) (6), (b) (2)

[redacted]

PUBLICATIONS:

Books

Published:

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Refereed Journals

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

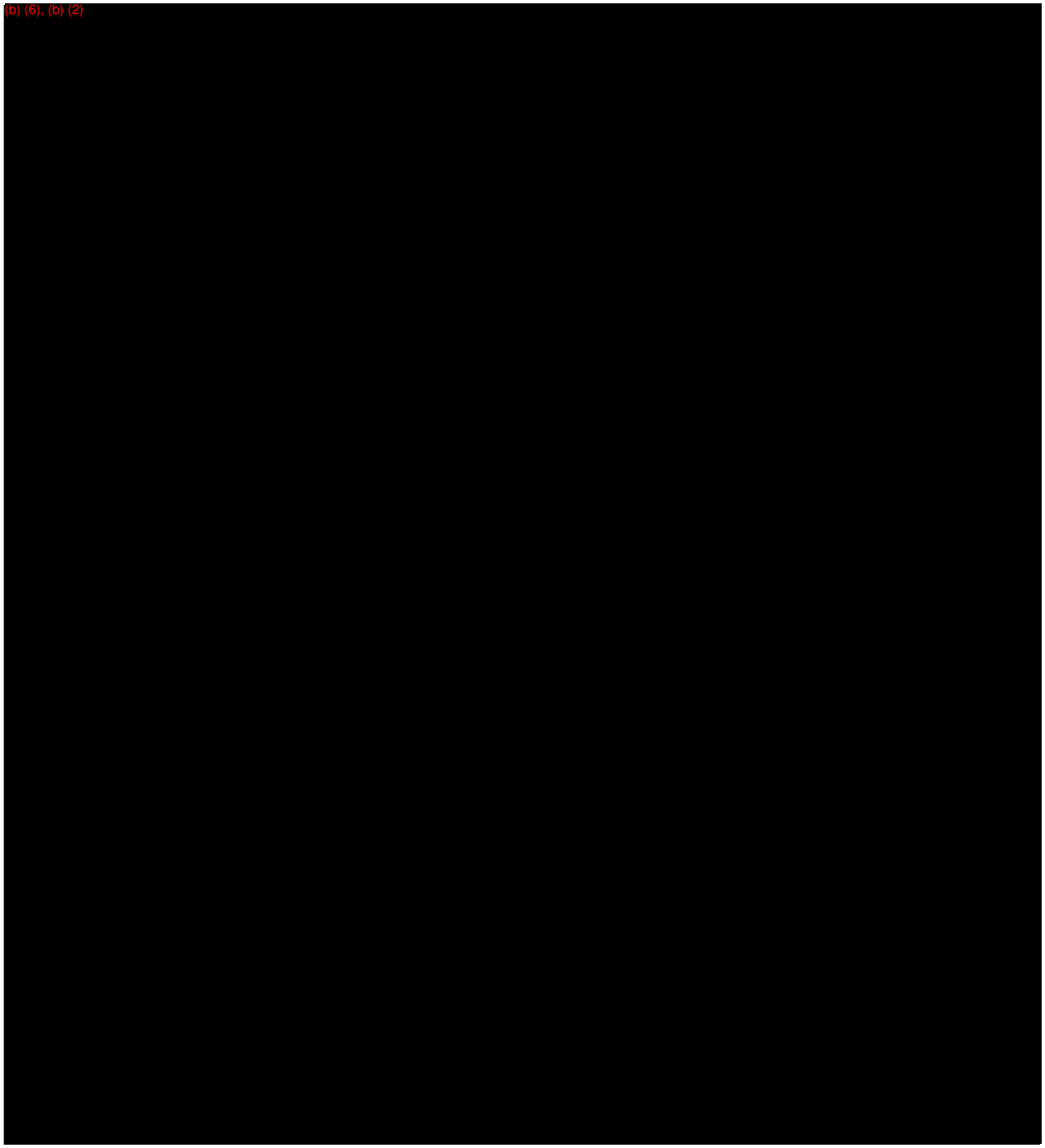
[redacted]

Electronic Publications: (These are probably aged to the point that the links no longer work)

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 10:02:19 PM
To: Va David [vacodjs1@va.gov]
Subject: Fwd: CIO
Attachments: (b) (6) Resume Mar 2017.docx; Untitled attachment 05690.htm

Sent from my iPhone

Begin forwarded message:

From: Bruce Moskowitz <(b) (6) mac.com>
Date: April 7, 2017 at 3:31:30 PM EDT
To: drshulkin@aol.com
Cc: IP <(b) (6) frenchangel59.com>
Subject: CIO

U of F

AMERICAN OVERSIGHT

(b) (6), (b) (2) RN, MBA

(b) (6), (b) (2)
Gainesville, Florida (b) (6), (b) (2)
Home Phone (352) 335-(b) (6), (b) (2)
Cell Phone (352) 214-(b) (6), (b) (2)
(b) (6), (b) (2) @shands.ufl.edu
(b) (6), (b) (2) @att.net

Summary:

(b) (6), (b) (2)
.

Professional Experience:

(b) (6), (b) (2)

(b) (6), (b) (2)

October 2011 - present
July 2009 – March 2010
1993 – 2011

(b) (6), (b) (2)

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

(b) (6), (b) (2)

[redacted]

1988 – 1991

1985 – 1988

–

1980 – 1983

Education:

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

Professional Licensure:

(b) (6), (b) (2) [redacted]

Affiliations:

(b) (6), (b) (2) [redacted]

Publications:

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/7/2017 9:40:41 PM
To: David shulkin [Drshulkin@aol.com]
CC: IP [(b) (6) frenchangel59.com]
Subject: Re: CIO

No go ahead we have 5 now including the one from Hopkins. All excellent I can get more

Sent from my iPhone

> On Apr 7, 2017, at 5:26 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> Bruce- thanks for the four CVs for CIO.
> Is it okay to contact them yet or do you want yo have discussions with them first?
>
> David
>
> Sent from my iPhone
>
>> On Apr 7, 2017, at 3:31 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>
>> U of F
>>
>> <(b) (6) Resume Mar 2017.docx>
>>
>>
>>
>> Sent from my iPad
>> Bruce Moskowitz M.D.
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 9:26:30 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: IP [(b) (6) frenchangel59.com]
Subject: Re: CIO

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Is it okay to contact them yet or do you want yo have discussions with them first?

David

Sent from my iPhone

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>
> U of F
>
> <(b) (6) Resume Mar 2017.docx>
>
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/7/2017 7:31:30 PM
To: drshulkin@aol.com
CC: IP [(b) (6) frenchangel59.com]
Subject: CIO
Attachments: (b) (6) Resume Mar 2017.docx; Untitled attachment 05696.txt

U of F

AMERICAN OVERSIGHT

(b) (6), (b) (2) RN, MBA

(b) (6), (b) (2)
Gainesville, Florida 32608
Home Phone (352) 335-(b) (6), (b) (2)
Cell Phone (352) 214-(b) (6), (b) (2)
(b) (6), (b) (2) @shands.ufl.edu
(b) (6), (b) (2) @att.net

Summary:

(b) (6), (b) (2)

.

Professional Experience:

(b) (6), (b) (2)

October 2011 - present
July 2009 – March 2010
1993 – 2011

(b) (6), (b) (2)

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

(b) (6), (b) (2) [redacted] 1991 – 1993

(b) (6), (b) (2) [redacted] 1988 – 1991

1985 – 1988

–

1980 – 1983

Education:

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

Professional Licensure:

(b) (6), (b) (2) [redacted]

Affiliations:

(b) (6), (b) (2) [redacted]

Publications:

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/7/2017 7:29:55 PM
To: drshulkin@aol.com
Subject: CIO
Attachments: 2017 March 2 (b) (6) CV.docx; Untitled attachment 05702.txt

U of Fl

AMERICAN OVERSIGHT

CURRICULUM VITAE {PRIVATE }

Name: [redacted]
Department: [redacted]
Health [redacted]
Present Rank: [redacted]
Business Address: [redacted], Gainesville, FL [redacted]
Business Telephone: 352-265- [redacted]
Home Address: [redacted], Gainesville, FL [redacted]

EDUCATIONAL RECORD:

Professional Development

[redacted]

Fellowship:

[redacted]

Residency:

[redacted]

Medical School:

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)
[redacted]

(b) (6), (b) (2)
[redacted]

Graduate:

(b) (6), (b) (2)
[redacted]arship

Undergraduate:

(b) (6), (b) (2)
[redacted]

BOARD CERTIFICATION:

(b) (6), (b) (2)
[redacted]

LICENSURE:

State	Number	Date	Status
(b) (6), (b) (2) [redacted]			

EMPLOYMENT:

Place of Employment City	Title or Position	Years of Empl.
(b) (6), (b) (2) [redacted]		

HONORS AND/OR AWARDS:

(b) (6), (b) (2)
[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

SERVICE/PATIENT CARE LEADERSHIP:

UNIVERSITY SERVICE:

(b) (6), (b) (2) [redacted]

COLLEGE OF MEDICINE SERVICE

(b) (6), (b) (2) [redacted]

COLLEGE OF MEDICINE, ADMISSIONS:

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

COLLEGE OF MEDICINE, OTHER

(b) (6), (b) (2)

[redacted]

(b) (6) COM, SEARCH COMMITTEES

(b) (6), (b) (2)

[redacted]

NATIONAL SERVICE

(b) (6), (b) (2)

[redacted]

COMMUNITY HOSPITAL - PATIENT LEADERSHIP

(b) (6), (b) (2)

[redacted]

(b) (6), (b) (2) HOSPITAL – FACULTY GROUP PRACTICE – [redacted] (b) (6),

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2) [redacted]

COMMUNITY SERVICE:

(b) (6), (b) (2) [redacted]

GRANT REVIEWS

(b) (6), (b) (2) [redacted]

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

(b) (6), (b) (2) [redacted]

EDUCATIONAL ACTIVITIES:

Curriculum Development

(b) (6), (b) (2) [redacted]

Evaluation Methods/Development

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

Family Practice noon conferences series (some old, some still being given)

(b) (6), (b) (2)

Older

(b) (6), (b) (2)

RAST (Resident AS Teachers)

(b) (6), (b) (2)

Preceptorships

(b) (6), (b) (2)

Other Lectures

(b) (6),

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Journal/Publication/Conference Submission Reviews

(b) (6), (b) (2)

[redacted]

PRESENTATIONS:

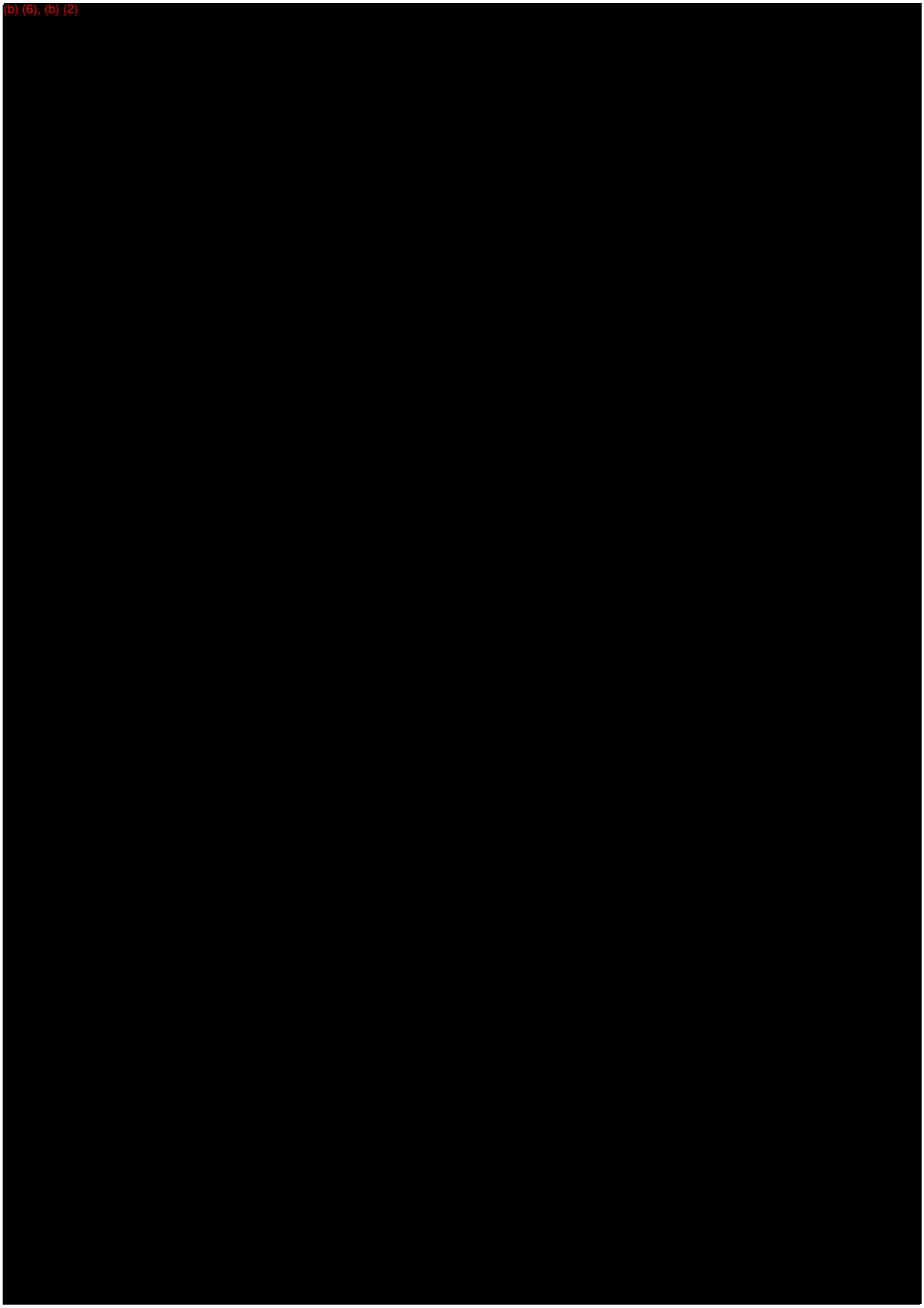
Invited Presentations, lecture, poster or other, Local, National and International

(b) (6), (b) (2)

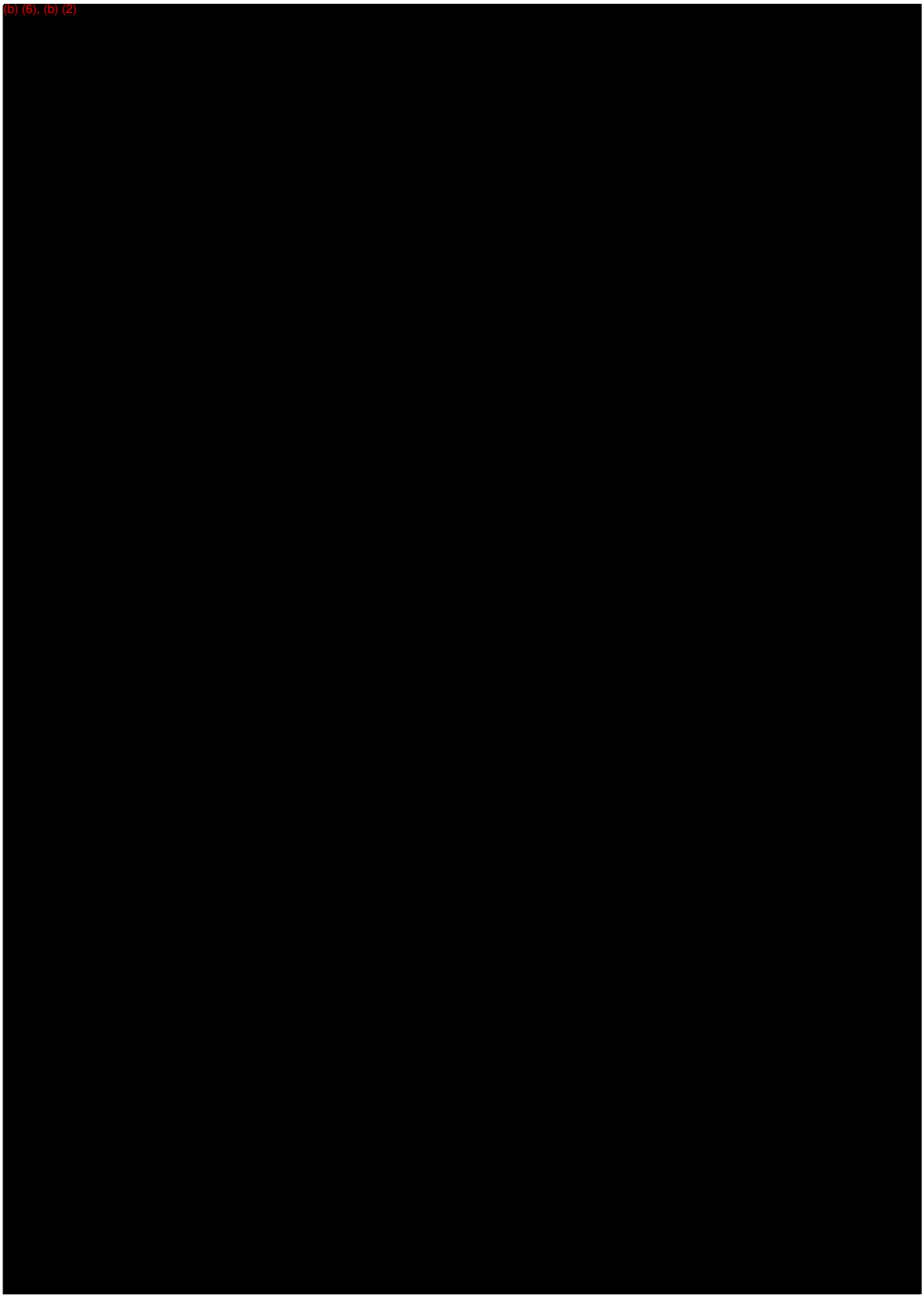
[redacted]

AMERICAN OVERSIGHT

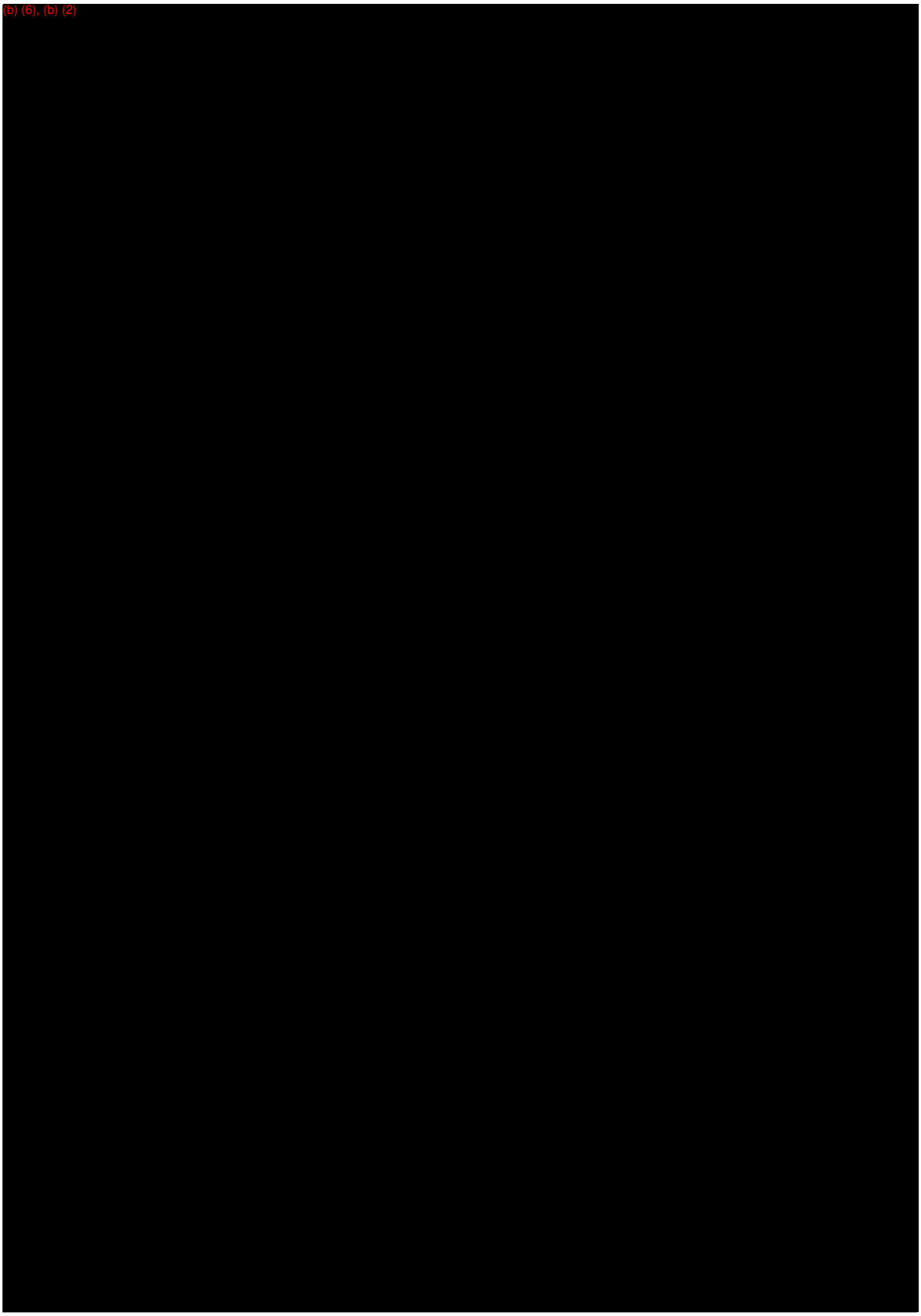
(b) (6), (b) (2)



AMERICAN OVERSIGHT



AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

(b) (6), (b) (2) .

LOCAL PRESENTATIONS

(b) (6), (b) (2)

CONTRACTS AND GRANTS:

(b) (6), (b) (2)

AMERICAN OVERSIGHT

MAJOR CONSULTATIONS OUTSIDE THE UNIVERSITY:

(b) (6), (b) (2)

[redacted]

PUBLICATIONS:

Books

Published:

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Refereed Journals

(b) (6), (b) (2)

[redacted]

Non-refereed Publications

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT

(b) (6), (b) (2)

[redacted]

Electronic Publications: (These are probably aged to the point that the links no longer work)

(b) (6), (b) (2)

[redacted]

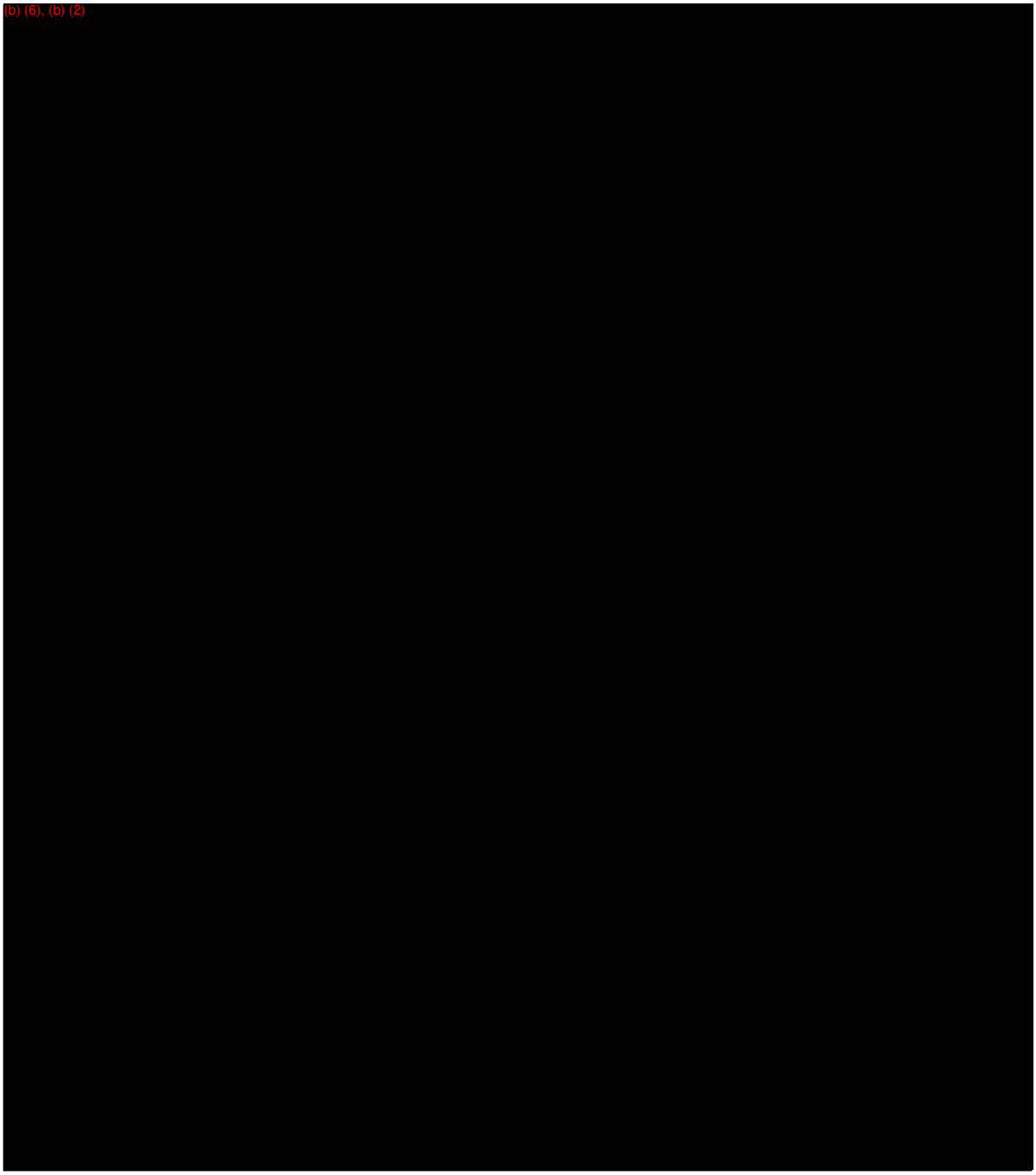
n,

ASK THE EXPERT Series http: www.medscape.com

(b) (6), (b) (2)

[redacted]

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/7/2017 12:14:31 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Draft EO on accountability and whistleblower protection

[redacted] sent it to me yesterday. It is the only VA EO that I have seen. Her first question to me when she called was have you seen the EO. Then why not.

Thanks for sending it, do we have some others out there waiting for WH approval.

Darin

On Thu, Apr 6, 2017 at 4:29 PM, David shulkin <Drshulkin@aol.com> wrote:
Have you seen this one?

Sent from my iPhone

Begin forwarded message:

> **From:** "(b) (6) [redacted] <(b) (6) [redacted] va.gov>
> **Date:** April 6, 2017 at 1:56:24 PM EDT
> **To:** 'David shulkin' <Drshulkin@aol.com>
> **Subject: Draft EO on accountability and whistleblower protection**

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:30:15 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]
Subject: Fwd: Draft EO on accountability and whistleblower protection
Attachments: Untitled attachment 05720.docx

Here is another EO

Im home now and up until 11pm

>
>

AMERICAN OVERSIGHT

EXECUTIVE ORDER

- - - - - - -

IMPROVING ACCOUNTABILITY AND WHISTLEBLOWER PROTECTIONS AT THE DEPARTMENT OF VETERANS AFFAIRS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Purpose. This order is intended to improve accountability and whistleblower protection at the Department of Veterans Affairs (VA) by directing the Secretary of Veterans Affairs (Secretary) to appoint a Special Assistant to serve as Executive Director of a newly-created VA Office of Accountability, Civil Rights, and Whistleblower Protection.

Sec. 2. Establishing a VA Office of Accountability, Civil Rights, and Whistleblower Protection. (a) Within 45 days of the date of this order, the Secretary shall establish a new VA Office of Accountability, Civil Rights, and Whistleblower Protection (Office), and shall appoint a Special Assistant, reporting directly to the Secretary, to serve as Executive Director (Executive Director) of the Office.

(b) The Executive Director shall advise and assist the Secretary in using all available authorities to discipline or terminate any VA manager or employee who has violated the public's trust and failed to carry out his or her duties on behalf of Veterans.

(c) The Executive Director shall work closely with Congress to identify options for legislative change to improve the Secretary's authority to discipline or terminate any employee who has jeopardized the health, safety, or well-being of a Veteran.

AMERICAN OVERSIGHT

(d) The Executive Director shall work closely with the White House Veterans hotline to ensure swift and effective resolution of Veterans' complaints of wrongdoing at the VA.

(e) The Executive Director will ensure adequate investigation and correction of wrongdoing throughout VA, and will ensure that honest employees who highlight wrongdoing are protected from retaliation.

(f) In establishing the Office described in paragraph 2(a) above, the Secretary shall consider, in addition to any other relevant factors:

(i) whether some or all of the functions of the Office are currently being performed by an existing VA office, component, or program

(ii) whether certain administrative capabilities necessary for operating the Office are redundant with those of another VA office, component, or program;

(iv) whether combining the Office with another VA office, component, or program may improve VA's efficiency, effectiveness, or accountability.

Sec. 3. General Provisions. (a) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(b) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

THE WHITE HOUSE,

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 11:29:16 PM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Fwd: Draft EO on accountability and whistleblower protection
Attachments: Untitled attachment 05725.docx; Untitled attachment 05728.htm

Have you seen this one?

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6) va.gov>
Date: April 6, 2017 at 1:56:24 PM EDT
To: 'David shulkin' <Drshulkin@aol.com>
Subject: Draft EO on accountability and whistleblower protection

AMERICAN OVERSIGHT

EXECUTIVE ORDER

- - - - - - -

IMPROVING ACCOUNTABILITY AND WHISTLEBLOWER PROTECTIONS AT THE DEPARTMENT OF VETERANS AFFAIRS

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AMERICAN OVERSIGHT

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THE WHITE HOUSE,

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/4/2017 2:32:40 PM
To: (b) (6) [(b) (6) hotmail.com]
Subject: Fwd: Re: Fwd:

John kelly and nicki haley have no money
Rick perry too

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <(b) (6) hotmail.com>
> **Date:** April 4, 2017 at 9:19:12 AM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: Re: Fwd:**
>
> Lol- it's just that the press simply loves you and doesn't want you to be dragged into any public controversy!! Your bubble will only get larger!
>
> Sent from my iPhone
>
> On Apr 4, 2017, at 12:11 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Its so small it was popped before it made it to the photo
> >
> > Sent from my iPhone
> >
> > On Apr 4, 2017, at 3:33 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
> >
> > > What happened to your bubble
> > >
> > > Sent from my iPhone
> > >
> > > On Apr 4, 2017, at 3:55 AM, David shulkin <Drshulkin@aol.com> wrote:
> > >
> > > > Sent from my iPhone
> > > >
> > > > Begin forwarded message:
> > > >
> > > > **From:** (b) (6) (b) (6) gmail.com>
> > > > **Date:** April 3, 2017 at 10:04:41 PM EDT
> > > > **To:** (b) (6) <drshulkin@aol.com>

AMERICAN OVERSIGHT

https://www.nytimes.com/interactive/2017/04/01/us/politics/how-much-people-in-the-trump-administration-are-worth-financial-disclosure.html?smid=fb-nytimes&smtyp=cur&_r=1

how much every cabinet secretary is worth

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/4/2017 1:19:12 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd:

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Sent from my iPhone

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>
> Sent from my iPhone
>
> On Apr 4, 2017, at 3:33 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > What happened to your bubble
> >
> > Sent from my iPhone
> >
> > On Apr 4, 2017, at 3:55 AM, David shulkin <Drshulkin@aol.com> wrote:
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** (b) (6) (b) (6) gmail.com>
> > **Date:** April 3, 2017 at 10:04:41 PM EDT
> > **To:** (b) (6) <drshulkin@aol.com>
> >
> > https://www.nytimes.com/interactive/2017/04/01/us/politics/how-much-people-in-the-trump-administration-are-worth-financial-disclosure.html?smid=fb-nytimes&smtyp=cur&_r=1
> >
> > how much every cabinet secretary is worth
> >
> > Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/4/2017 11:11:08 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Fwd:

Its so small it was popped before it made it to the photo

Sent from my iPhone

On Apr 4, 2017, at 3:33 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

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> >
> > how much every cabinet secretary is worth
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> > Sent from my iPad

AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/4/2017 7:33:23 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd:

What happened to your bubble

Sent from my iPhone

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>
> how much every cabinet secretary is worth
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/4/2017 2:55:59 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd:

Sent from my iPhone

Begin forwarded message:

From: (b) (6) (b) (6) gmail.com>
Date: April 3, 2017 at 10:04:41 PM EDT
To: (b) (6) <drshulkin@aol.com>

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how much every cabinet secretary is worth

Sent from my iPad

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how much every cabinet secretary is worth

Sent from my iPad

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/19/2017 11:43:18 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Actual cbs clip here. Does this work?

Yes - I'll want it for me to play on the 25 th

Sent from my iPad

On Apr 19, 2017, at 7:37 PM, (b) (6) <(b) (6) gmail.com> wrote:

> http://www.cbsnews.com/videos/wounded-vet-frustrated-with-weeks-long-delays-in-local-va/?ftag=CNM-00-10aab4i

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/19/2017 11:37:47 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Actual cbs clip here. Does this work?

http://www.cbsnews.com/videos/wounded-vet-frustrated-with-weeks-long-delays-in-local-va/?ftag=CNM-00-10aab4i

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/9/2017 12:25:13 AM
To: (b) (6) gmail.com
Subject: Re: Documents you typed on my computer

thanks

-----Original Message-----
From: (b) (6) <(b) (6) gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sat, Apr 8, 2017 8:24 pm
Subject: Re: Fwd: Documents you typed on my computer

Folders were put together yesterday for signature on Monday. I will email the letters after you sign them

On Apr 8, 2017 8:23 PM, "David Shulkin" <drshulkin@aol.com> wrote:
Do you know if we have sent out the invites to the Secretarys Advisory Board yet?

-----Original Message-----
From: (b) (6) <(b) (6) gmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Mon, Apr 3, 2017 5:28 pm
Subject: Documents you typed on my computer

ACMO is working on doc 1 under MyvA advisory committee

(b) (6)

---------- Forwarded message ----------
From: (b) (6) <(b) (6) gmail.com>
Date: Thu, Mar 30, 2017 at 7:54 PM
Subject: Documents from last night
To: David Shulkin <drshulkin@aol.com>

attached

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/9/2017 12:24:33 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Fwd: Documents you typed on my computer

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[redacted]

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From: David Shulkin [drshulkin@aol.com]
Sent: 4/9/2017 12:23:24 AM
To: (b) (6) gmail.com
Subject: Fwd: Documents you typed on my computer
Attachments: advisoryletter.docx; annals.docx

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AMERICAN OVERSIGHT

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The Secretrary's Advisory Board will focus on strategic directions and policy issues that facing VA and veterans. The Board will consist of approximately members and meet three times a year for one day each. Meetings will usually be held in Washington DC or on occasion in a field location.

I realize that you are busy and I am appreciative of your consideration of this important work. I look forward to hearing from you.

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AMERICAN OVERSIGHT

Putting Veterans in Control of Their Care

The 2014 access crisis at the Department of Veterans Affairs was a pivotal moment for VA. Daily media accounts, like non-stop drumbeats- reported that Veterans were on long waitlist for care and at suggested that some were dying while they . The extent of VA's access problems, like many others in US Health care, was not immediately clear. The Department had difficult to understand wait time metrics exacerbated by arbitrary scheduling goals that it could not meet. Those hard-to-meet and hard to measure goals led to allegations of secret and covert waitlists which resulted in a loss of confidence and trust in the system.

In, the wake of the crisis and in response to a public outcry VA began publicly posting patient wait time data on line. Few , if any, health systems were doing this and in its' efforts to be transparent, VA forged new ground in doing so. We consulted with the National Academy Medicine and a number of other industry and thought leaders it became clear that no standards for wait times existed and VA would have to create a new set of terminology. What followed was reports on appointments from the time they were requested, created, completed, when the patient wanted the appointment, when the clinician wanted the on (using 31 different preferences to order a consult). With more than 50 million appointments a year, and descriptive statistics on appointments in a large number of different ways

VA is also transitioning from a system that focused almost exclusively on data that compared its performance to others in the VA system, to comparisons with the private sector. While numerous independent assessments have found that overall VA provides care that is comparable with or superior to the private sector, we recognize that overall metrics obscure weak performance in selected facilities and furthermore that veterans seek care comparisons in their local community and not at the national level.

For decades, VA has led the healthcare in reporting on comprehensive performance metrics that are not readily reported by most other healthcare organizations. We believe our measures enable high performance and include extensive ambulatory measures, behavioral healthcare metrics, and leadership and nursing turnover rates. Called Strategic Analytics for Improvement and Learning (SAIL) we invite others to adopt these metrics so our comparisons to the private sector become more robust.

As part of VA's modernization efforts, focusing on veterans needs and preferences, VA has launched on line informant on wait times, veteran experience, and quality that veterans can use to make decisions about their care.

As we continually improve this approach, guided by veterans feedback, we hope others in the community will join us. This will allow veterans to seek the care that is best for them and to be able to find care either in the vA, or in the community, that best fits their needs and delivers optimal outcomes.

The VA of the future must be based on what veterans want and how they want to receive care. In his book, "Best Care Anywhere" author Philip Longman described the VA healthcare system as a model system of care. Ten years later, as we define our network to include both the VA system and our federal, academic, and community partners, we seek to expand Longman notion and believe that we are on the cusp on being able to deliver the best care everywhere.

AMERICAN OVERSIGHT

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I recall sitting in a radio interview with a reporter trying to interpret our online wait time data and it became apparent to me in do so that that we had created metrics so complex that despite my best efforts few people were likely to understand what I had said. I realized then and there that there needed to be a better way

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AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/3/2017 9:27:32 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Documents you typed on my computer
Attachments: advisoryletter.docx; annals.docx

ACMO is working on doc 1 under MyvA advisory committee

[redacted]

---------- Forwarded message ----------
From: [redacted] <[redacted]gmail.com>
Date: Thu, Mar 30, 2017 at 7:54 PM
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To: David Shulkin <drshulkin@aol.com>

attached

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 5/4/2017 10:08:43 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David shulkin [Drshulkin@aol.com]
Subject: Re: Suicide prevention

Thanks so much- you are such an awesome partner!! We will make a difference in Suicide Prevention- that is our conviction!!

Sent from my iPhone

> On May 4, 2017, at 12:35 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Very important ultimately we need their resources to have more psychologists and psychiatric services available to the VA. That is my main goal.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
>> On May 4, 2017, at 12:30 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> We have the most advance analytics on this- called reachvet if its helpful
>>
>> Sent from my iPhone
>>
>>> On May 4, 2017, at 12:29 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>>
>>> (b) (6) the President of the U of PENN has agreed to work with me to put together a consortium to work on early detection of who is at risk and a consortium to have more resources for treatment. We need more resources for the VA to solve the problem and also this is important to decrease University suicide risk.
>>>
>>> Sent from my iPad
>>> Bruce Moskowitz M.D.
>>

AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 5/4/2017 4:30:51 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Suicide prevention

We have the most advance analytics on this- called reachvet if its helpful

Sent from my iPhone

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AMERICAN OVERSIGHT

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CC: David shulkin [drshulkin@aol.com]
Subject: Suicide prevention

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Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) gmail.com]
Sent: 4/16/2017 4:04:50 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Yes
On Sun, Apr 16, 2017 at 11:58 AM David shulkin <Drshulkin@aol.com> wrote:
Can we talk about telling the wsj tommorow about the WH correspondents dinner ?

Sent from my iPhone

--
Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/16/2017 3:58:26 PM
To: (b) (6) [(b) (6) gmail.com]

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 1:56:16 AM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: [EXTERNAL] FW: VA Secretary Praises Congress for Extending Choice Program

Ok I trust your judgement

Sent from my iPad

On Apr 5, 2017, at 9:10 PM, Darin Selnick <(b) (6) @gmail.com> wrote:

> Yes, he is the guy who has been catching and fixing issues in OCLA despite not having any authority. We would not have ever fixed the Sen Lee hold without him, he was the guy who organized and led the quick response for the McCain and Lee staff and they are very grateful. Once in as Asst Sec, he is ready to overhaul and lead OCLA to be a well run machine.
>
> I do not know what you are hearing that would be of concern about Brooks, if you want to share them I can give you my perspective.
>
> Darin
>
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> Sent from my iPhone
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> > -----Original Message-----
> > **From:** (b) (6) (Moran) [(b) (6) moran.senate.gov]

AMERICAN OVERSIGHT

Sent: Wednesday, April 05, 2017 05:27 PM Eastern Standard Time
To: Selnick, Darin
Subject: [EXTERNAL] FW: VA Secretary Praises Congress for Extending Choice Program

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Cc: (b) (6) (Moran) <(b) (6) moran.senate.gov>; (b) (6) (Moran) <(b) (6) moran.senate.gov>
Subject: FW: VA Secretary Praises Congress for Extending Choice Program

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Sent: Wednesday, April 05, 2017 5:20 PM
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AMERICAN OVERSIGHT

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Sent: 4/6/2017 1:03:02 AM
To: Darin Selnick [(b) (6) @gmail.com]
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AMERICAN OVERSIGHT

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 1:01:55 AM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: [EXTERNAL] FW: VA Secretary Praises Congress for Extending Choice Program

Good pick up

Thanks

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AMERICAN OVERSIGHT

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Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/6/2017 12:46:24 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Fwd: FW: [EXTERNAL] FW: VA Secretary Praises Congress for Extending Choice Program

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 3:47:40 PM
To: David Shulkin [drshulkin@aol.com]
CC: Marc Sherman [(b) (6) gmail.com]
Subject: Re: Infrastructure

Marc- we can discuss more when we meet

David

Sent from my iPhone

On Mar 31, 2017, at 11:32 AM, (b) (6) (b) (6) va.gov> wrote:

> Good Morning Marc,
>
> Dr. Shulkin asked that I share the analysis of the initial realignment proposals for our facilities (first attachement). Additionally, please find the recommendation from our staff (powerpoint) to request congress establish a BRAC to facilitate this process.
>
> (b) (6)
>
> <Infrastructure Background - Facilities.pdf>
> <SECVA Briefing Independent Review Commission for VHA Facilities and Capi....pptx>

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]va.gov]
Sent: 3/31/2017 3:32:22 PM
To: 'Marc Sherman' [redacted]gmail.com]; 'drshulkin@aol.com' [drshulkin@aol.com]
Subject: Infrastructure
Attachments: Infrastructure Background - Facilities.pdf; SECVA Briefing Independent Review Commission for VHA Facilities and Capi....pptx

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[redacted]

AMERICAN OVERSIGHT

1. Background

The United States (US) Department of Veterans Affairs (VA) operates one of the largest, integrated health care systems in the country. It delivers this care through over 1,600 points of care that it either leases or owns outright.

Over the decades, as the US Veteran population has migrated, VA's capital infrastructure has not been able to keep pace with those changes due to the inability to rapidly divest from its operating locations where Veterans were moving from (legacy locations) to where Veterans were moving. Additionally, as care delivery models shifted away from long inpatient stays to greater outpatient care, VA has increasingly found itself with capital infrastructure not ideally suited to current trends in health care.

VA has initiated or participated in numerous studies over the past decade, or so, focused on better aligning health care facilities to more efficiently deliver health care to Veterans.

This document provides results of a recent summary data call performed by the Veterans Health Administration (VHA) that requested input from VHA's operating networks as to viable options to realign facilities to more efficiently deliver care to Veterans.

The summary contained in this document does not include financial impact of realignments nor does it assess the political feasibility of such realignments.

2. Initial Realignment Proposals

Table 2-1 provides a listing of Veterans Integrated Service Network (VISN) and Facility of potential realignments. These realignments result in a partial or full closure of a facility. In most all cases, the realignment would require a short term investment of resources (e.g. establishing a large Community Based Outpatient Clinic – CBOC, expanding services in another VA Medical Center to absorb workload, etc.). Overall, there are eighteen facilities identified where some form of realignment could be implemented. Of these realignments, five realignments result in the outright closure of current major facilities. Eleven of the proposed realignments result in the discontinuation of inpatient services at a given facility and then align those inpatient services at another VA facility or within the private sector community. One proposed realignment results in adjustment of certain services between already existing facilities.

Table 2-1: Proposed Alignment of VA Health Care Facilities

VISN	Facility	Facility Closure Involved in Realignment	Initial Proposal
VISN 2	Canandaigua (528A5)	Partial – Canandaigua	Merge facility with Bath; realign Rochester CBOC to Western New York Health Care System – HCS (Buffalo)
	Bath (528A6)	Partial – Canandaigua	Merge facility with Canandaigua - Domiciliary will fall within current Bath facility
VISN 3	VA Hudson Valley HCS-Castle Point Division (620A4)	Yes – Castle Point	Propose closing and vacating Castle Point HCS and transfer care to other VISN 3 facilities

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VISN	Facility	Facility Closure Involved in Realignment	Initial Proposal
	Brooklyn (630A4)	Partial – Brooklyn	Move all inpatient beds from Brooklyn to Manhattan campus
	St. Albans (630A5)	Partial – St. Albans	Vacate and develop a multi-service CBOC on current site – Inpatient and community living center care will be transferred to other VISN 3 facilities
VISN 4	VA Pittsburgh HCS	No	VA fully discontinued services at the Highland Drive Campus and retired its station number, VA seeks to excess the property through GSA
VISN 7	Dublin (557)	Partial – Dublin	Close inpatient services, maintain outpatient surgery - refer complex cases to Augusta or Atlanta
VISN 9	Middle Tennessee Health Care System	No	Close Nashville unit 4B (MH) and transfer work to York - close all IP medicine beds at York and transfer work to Nashville.
VISN 11	Battle Creek (515)	Partial – Battle Creek	Close inpatient Medical/Surgical beds, retain IRR & Community Living Center
	Illiana HCS (Danville) (550)	Partial – Illiana	Close inpatient Medical / Surgical and retain acute Mental Health, IRR
	Saginaw (655)	Partial – Saginaw	High potential - will become a HCC
VISN 15	Eastern Kansas HCS Leavenworth Division (589A6)	Partial – Leavenworth	Viable Candidate - no detailed plans given
VISN 18	West Texas HCS (Big Spring) (519)	Yes – Big Spring	Close inpatient services and move health care to Amarillo; close Domiciliary and Community Living Center - vacate HCS
	Prescott (649)	Yes – Prescott	Close inpatient – eliminate Emergency Department; align with Phoenix; expand Community Living Center
VISN 19	Grand Junction (575)	Partial – Grand Junction	Close inpatient beds and use community contracts
VISN 20	Roseburg HCS (653)	Partial – Roseburg	Close inpatient (possible) operate as a CBOC + IRR and Community Living Center
VISN 21	Livermore (640A4)	Yes – Livermore	Planning to close - move all care to Stockton and Freemont
VISN 23	Fort Meade (568)	Partial – Fort Meade	Plan to contract inpatient to community - retain Community Living Center
	Hot Springs (568A4)	Yes – Hot Springs	Plan to close IP services and contract with community providers - expand multi-specialty care clinic in Rapid City

The proposed realignment associated with the VISN 23 Hot Springs facility has already been initiated, and the VA is currently conducting an environmental impact analysis.

The nature of cost savings in the identified realignments may be realized in the reduction of both labor costs and in certain other fixed and variable facilities' costs.

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3. Further Analysis

The identified facilities represent the result of a data call. Where a realignment has been proposed the VISN has developed a notional end-state vision for services to be provided to Veterans, a high-level project sequence, and very rough estimate timeframe.

It is proposed that further analysis be performed by forming an integrated program of VISN teams supported by a projects coordinator within VHA's Network Operations (10N). This effort will require support from VHA's Office of Policy and Planning, and VA's Office of Management.

The effort should be pursued with the assumption that the identified capital realignments will be included in FY17, 18 and 19 Budget Cycles.

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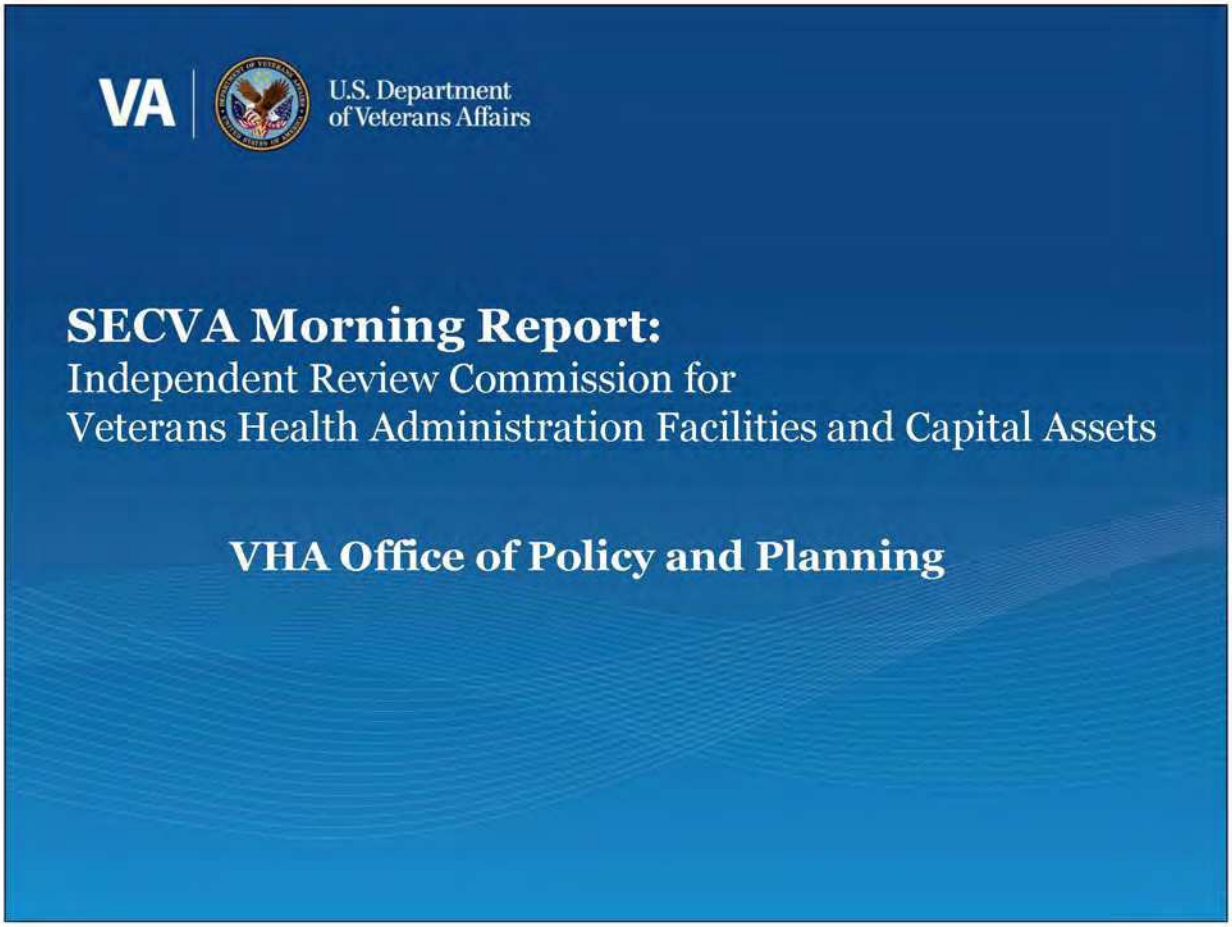

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- Background and Purpose
- Recommendation
- Principles
- Lessons Learned
- Timeline
- Legislative Technical Assistance
- Communications

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BACKGROUND AND PURPOSE

- In February, the VHA NLC recommended establishment of a VHA facilities review commission (similar to DOD's Base Realignment and Closure (BRAC) Commission) as a top "big hairy audacious change", which stemmed in part from CARES Commission lessons learned, the Section 201 Independent Assessments (2014) and Commission on Care (2016) reports
- SECVA requested a recommended path forward for the review
- A tiger team was established – including Sr. Advisors to SECVA, OPP, OAEM, OCFM, OCAMES, OGC, OSI – to weigh the options:

  Option 1 : a Statutory VA Advisory Commission ← recommended option

  Option 2 : a Discretionary VA Advisory Committee
- The tiger team is now presenting its recommendation to SECVA, including
  - Suggested methodology/approach
  - Timeline
  - Legislative Technical Assistance
  - Communications strategy to accompany the initiative

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RECOMMENDATION

- It is recommended by the tiger team that VA request Congress to pass legislation requiring VA to establish a Statutory VA Advisory Commission for the realignment of VHA facilities (i.e. Option 1)
- The recommendation for a Statutory VA Advisory Commission is based on the following rationale:
  - Recommendations from a Statutory VA Advisory Commission would have a higher likelihood of receiving an approval/disapproval vote from Congress on the entire recommendations package, since Congress required VA to establish the Commission
  - Congress could appropriate funds for the Commission, to include funds for staff and Contractors (if necessary); and
  - Congress could provide, by statute, that the Commission is FACA-exempt

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PRINCIPLES IN DEVELOPING A NATIONAL REALIGNMENT PLAN

- Several principles will guide development of the national realignment plan and subsequent decisions by the Commission. Some include:
  - Balance the need for equal or better access, Veteran satisfaction, state-of-the-art world-class facilities, and cost-effectiveness
  - While addressing VA's health care mission, preserve VHA's other missions – education, research and emergency preparedness
  - The quality of VA and community care will be examined to ensure suitable facilities and well-trained health care professionals are available to meet the needs of Veterans
  - Assure a high performing clinically integrated network of VA care and community care, which may include adding sites of care where population and referral patterns indicate access needs to be improved
  - Leverage lessons learned from CARES Commission and DOD BRAC Commission

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LESSONS LEARNED

- Some lessons learned from the CARES Commission and BRAC Commission process will be incorporated in the independent review and the National Realignment Plan that VA will submit to the Commission:
  - A number of CARES initiatives were never implemented because members of Congress and special interest groups blocked closure of facilities that the CARES Commission verified were no longer needed
  - Avoid adding requirements after implementation begins and fully account for IT requirements in initial estimates to prevent understating costs
  - In general, the Commission would not be able to add recommendation contingencies, but if contingencies are to be permitted, limit them to specific conditions
  - Requirements such as environmental clean-up before transfer or re-use and historical preservation hindered full implementation
  - BRAC analysis did not give a credible assessment of total excess capacity across DOD or the potential for achieving greater efficiencies in use of that capacity - this could be an issue with VHA as well
  - Not considering property transfer/disposal process once the BRAC closure process completed seemed to prolong moving of the liability, which slowed realizing cost savings

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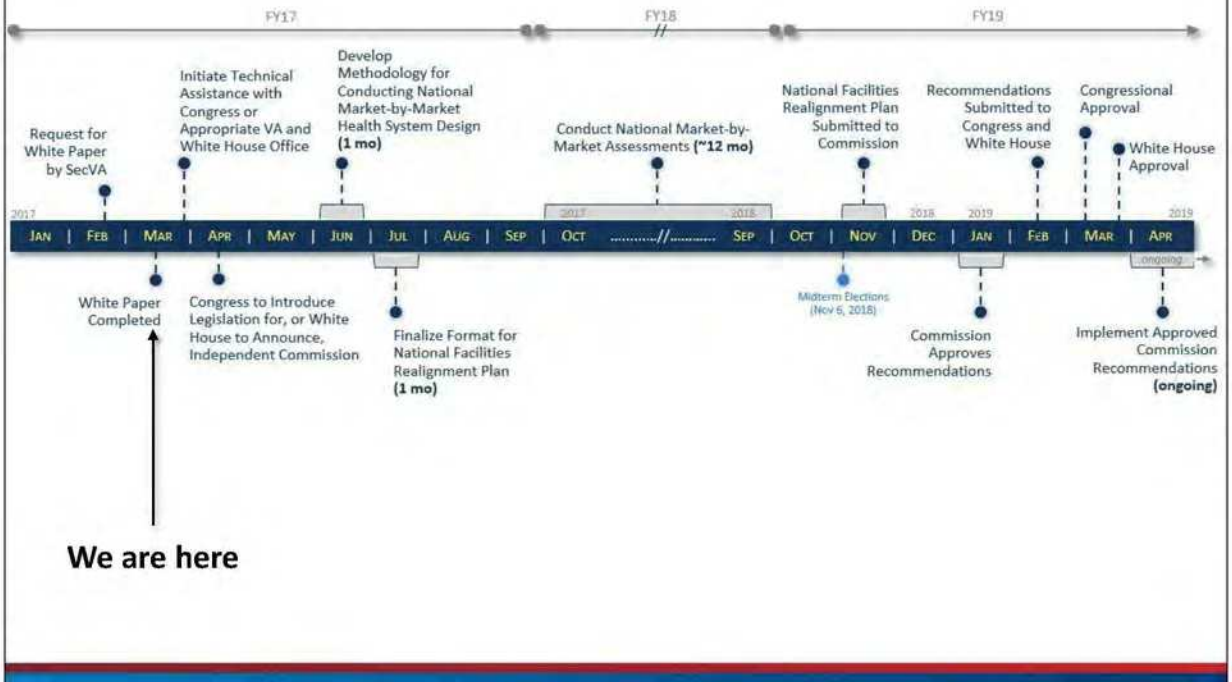
SUGGESTED TIMELINE



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LEGISLATIVE TECHNICAL ASSISTANCE

- Establish a Statutory VA Advisory Commission comprised of members appointed by the WH and Congress with ex-officio expert members from VA facilities and VHA health care
- Offer legislative assistance on inclusion of review criteria based on access, quality, safety and community facility standards
- Congress has up or down vote on entire plan as a whole
- Criteria can be used for future decisions on capital by SECVA
- Empower the Commission to assess and approve VA/VHA's national realignment plan within 45 days of receipt of VHA's recommendations
- Insert language to preclude members of congress from blocking implementation in their districts

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COMMUNICATIONS

- Need a focused and deliberate communications strategy to accompany the work of the Commission – before and during the assessments, and during implementation
- Communicate to Congress, the Commission, Veterans, VA employees, VSOs, Union partners, and other stakeholders
- Requires a comprehensive multi-media strategy
- Expand routine communications between the markets, VISNs and VHACO, to encourage joint resolution of common challenges, and sharing of best practices and lessons learned in managing mission changes
- Continually accentuate the benefits in terms of equal or greater access, quality, satisfaction, and economic benefits

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 6/12/2017 6:45:35 PM
To: Bruce Moskowitz [(b) (6) mac.com]; Ike Perlmutter [(b) (6) frenchangel59.com]
Attachments: IMG_4068.JPG; Untitled attachment 05908.txt

Roundtable list

AMERICAN OVERSIGHT

Committee on Veterans' Affairs
U.S. House of Representatives
115th Congress

"Improving Access, Quality, and Efficiency: Exploring Organizational Changes for the Veterans Health Administration"

Thursday, June 15, 2017, at 8:00 a.m.
334 Cannon House Office Building

1. **James B. Peake M.D., LTG (Ret),** Senior Vice President, CGI Federal/Former Secretary, U.S. Department of Veterans Affairs
2. **Katrina Armstrong MD,** Jackson Professor of Clinical Medicine, Harvard Medical School
3. **Christine Cassel, M.D.,** Kaiser Permanente School of Medicine/Former President and Chief Executive Officer, National Quality Forum
4. **George Halvorson,** Chair and Chief Executive Officer, Institute for Intergroup Understanding/Former Chairman and Chief Executive Officer, Kaiser Permanente

   Accompanied by: LaVerne Council, MITRE Corporation/ Former Chief Information Officer, U.S. Department of Veterans Affairs
5. **Gail Wilensky, Ph.D.,** Senior Fellow, Project HOPE
6. **David Hecht, M.D., M.B.A.,** Chief of Staff, Mountain Home VA Healthcare System, U.S. Department of Veterans Affairs
7. **Paul Rothman, M.D.,** Dean and Chief Executive Officer, Johns Hopkins Medicine
8. **Peter Pronovost, M.D.,** Senior Vice President, Patient Safety and Quality, Johns Hopkins Medicine
9. **Sam Hazen**, President, HCA
10. **The Honorable David Shulkin,** Secretary, U.S. Department of Veterans Affairs

    Accompanied by: Dr. Poonam Alaigh, Acting Under Secretary for Health, U.S. Department of Veterans Affairs
11. **John Noseworthy, M.D.,** President and Chief Executive Officer, Mayo Clinic

DS_00002893
AMERICAN OVERSIGHT
VA-19-0799-D-001222

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 11:30:32 AM
To: Poonam Alaigh [(b) (6) hotmail.com]; Bruce Moskowitz [(b) (6) mac.com]
Subject: Fwd: [EXTERNAL] Project Hero launches PTSD device to eliminate suicide

Poonam and Bruce- this is an interesting device that we might want to look at-
Im not sure if yiu have seen this before. Poonam you may wish to share with out clinical team. i am seeing the developer on thursday

David

Subject: [EXTERNAL] Project Hero launches PTSD device to eliminate suicide

PROJECT HERO ANNOUNCES PARTNERSHIP WITH TEXAS A&M UNIVERSITY TO LAUNCH INNOVATIVE PTSD DEVICE

HERO TRAK

Project Hero, the groundbreaking national non-profit veterans and first responders organization, will partner with Texas A&M University to introduce the first wearable biometric monitoring device specifically designed to help veterans and first responders with PTSD, it was announced today by (b) (6) president and founder of Project Hero.



The device will debut as part of Project Hero's HEROTrak program during the organization's upcoming 2017 UnitedHealthcare Texas Challenge April 3-8.

The partnership features the debut and first non-clinical use of a wristwatch-sized wearable biometric monitor programmed to respond to and learn the wearer's PTSD-specific physical triggers to predict episodes and provide tools to strengthen resilience. The device uses heart rate, skin conductance and heart rate variation, not associated with athletics or normal activities, and interact with the wearer to help manage the onset of the episode and allow tools including contact peer support or assistance.

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The unique device and its sophisticated monitoring software have been developed by the Engineering Department of Texas A&M University. The university has been working with the Project Hero Research Institute of Mental Health to develop opportunities to test the device using highly-qualified veterans in non-clinical environments such as Project Hero events.

The organization has selected veteran and first responders who have a VA mental health rating taking part in the 2017 UnitedHealthcare Texas Challenge for the inaugural study. The riders will wear the device throughout the 350+-plus mile journey through from San Antonio to Houston.

"Project Hero is honored by our partnership with Texas A&M and thrilled to be the first organization serving veterans and first responders to use the HERO Trak device that will help wearers identify, manage and reduce PTSD episodes," said Wordin. "We are also planning to continue working with Texas A&M using this innovative device at our Challenge Series and other events throughout the year."

Riders will wear the HERO Trak device throughout the 2017 UnitedHealthcare Challenge Series and allow data generated by the device to collected on an anonymous basis by Project Hero and Texas A&M after the Challenge has ended. Project Hero and Texas A&M are planning to use the device in the organization's upcoming 2017 Challenge and Honor Ride events to improve the predictability and accuracy.

A companion App is being developed with Project Hero, the VA, and other partners. The goal is to increase resources so that more veterans can take part in the initial study phase to provide more data to perfect the relevant algorithms.

We appreciate all of the veterans and partners taking part in this groundbreaking initiative and look forward to a future where all military personnel would have access to this information from the time they start their military service through their transition into the VA system to provide a more accurate and personalized continuum care path and eliminate suicide.

Regards,

(b) (6)
President and Founder
Project Hero
Providing Hope Recovery & Resilience
818.888.7(b) (6)
818.710(b) (6) Fax
ProjectHero.org

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PROJECT HERO
Research Institute of Mental Health
Hope Recovery Resilience

Supporters include UnitedHealthcare, GE, United Airlines, USO, Hero Miles, Tawani Foundation, Disabled Veterans National Foundation, Scott USA, Uhaul, Bike Nashbar, Pactimo, Macy's, Shimano, Boeing, Strohman Enterprise Garmin, Camelbak, Rocktape, Parktool, Speedplay, Geico, Chamois Butt'r, Hutchinson, Kenda, Pepsi, Gatorade, Soldier Fuel, ICC, R4 Alliance and is the creator and founding partner of the Warrior Games.

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Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/4/2017 5:02:49 PM
To: drshulkin@aol.com; Poonam Alaigh [(b) (6) hotmail.com]
Subject: Congressional hearing on VA CRISIS LINE

The staff did a great job under difficult circumstances. The points that stood out in my mind are the following:
By the time the VA gets the patient who calls there is no prior system within the DOD to let the VA know who may be at risk and a focus of a mental wellness program.
Telemedicine instant link with a patient who calls may be necessary in many locations.
A focus was on women during the hearing and we should be able to come up with a women's health care initiative very quickly.

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/4/2017 12:12:31 AM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Academic Affiliations SECVA

Ok ill respond and get back to you

Sent from my iPhone

On Apr 3, 2017, at 8:01 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:

> It would be my pleasure to take the lead if you believe it to be of benefit and indeed they make a case for the same issues we have identified.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
> On Apr 3, 2017, at 7:19 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Bruce- i just wanted you to be aware - so we coordinate efforts
> >
> > Im ok if you take the lead
> >
> > David
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** DJS <vacodjs1@va.gov>
> > **Date:** April 3, 2017 at 6:58:15 PM EDT
> > **To:** 'Shulkin ' <drshulkin@aol.com>
> > **Subject: FW: Academic Affiliations SECVA**
> >
> > Sent with Good (www.good.com)
> >
> > -----Original Message-----
> > **From:** (b) (6)
> > **Sent:** Monday, April 03, 2017 05:23 PM Eastern Standard Time
> > **To:** DJS
> > **Subject:** FW: Academic Affiliations SECVA
> >
> > Sent to (b) (6) already

AMERICAN OVERSIGHT

From: [redacted] [mailto[redacted]mssm.edu]
Sent: Monday, April 03, 2017 4:09 PM
To: Shulkin, David J., MD
Cc: [redacted]
Subject: [EXTERNAL] Academic Affiliations SECVA

Dear Dr. Shulkin,

We would like to take this opportunity to respond to your call for ideas for building academic partnership for faculty, training, and research.

The Icahn School of Medicine at Mount Sinai has had a longstanding affiliation of over 30 years with the Veterans Affairs Hospital in the Bronx, New York (VA). We have shared a history of successful achievements including two Lasker Awards and a Nobel Prize in research. However in order for the VA to continue its successful 70 year partnership with academic institutions, the VA must move forward with audaciousness and a renewed energy.

There is a need to streamline and expedite the hiring processes between the VA and the affiliations. A process is needed that promotes swift onboarding, functional privileges and efficient portable Heath IT access. There is a need to develop safe and secure exchange of patient and research information across the VA and affiliated institutions for shared patients and for research information and research protocols. This will require a fresh look at interoperability between IT platforms at the VA and the affiliate.

It is critical that the VA strongly continues the support of research development in order to remain viable with a critical mass of research and also to continue to attract the best research talent in the community. We must maintain adequate funding of veteran centric clinical and research development, both in general veteran focused areas of care delivery and research including women's health, PTSD, and long term effects of concussion but also in the highly specialized treatment of veterans and their loved ones that the VA provides for the more rare but devastating conditions of spinal cord injury, ALS, MS, Alzheimer's Disease, along with Centers of Excellence in Suicide prevention.

To more effectively task those important issues we encourage moving more resource and research decisions to local director leadership instead of centrally, because facility directors are able to make more informed decisions based on availability of local clinical and research expertise and excellence in the local community, academic affiliation, and the VA medical center.

Sincerely,

AMERICAN OVERSIGHT

[redacted] MD

[redacted] MD

President & CEO,

[redacted] Dean,

Mount Sinai Health System

of Medicine at Mount Sinai

Academic Affairs,

Health System

[redacted]

[redacted]

Icahn School

President for

Mount Sinai

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) [redacted]mac.com]
Sent: 4/4/2017 12:01:20 AM
To: David shulkin [Drshulkin@aol.com]
CC: Poonam Alaigh [(b) (6) [redacted]notmail.com]; Ike Perlmutter [(b) (6) [redacted]frenchangel59.com]
Subject: Re: Academic Affiliations SECVA

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Sent from my iPad
Bruce Moskowitz M.D.

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> **Date:** April 3, 2017 at 6:58:15 PM EDT
> **To:** 'Shulkin ' <drshulkin@aol.com>
> **Subject: FW: Academic Affiliations SECVA**
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> Sent with Good (www.good.com)
>
> -----Original Message-----
> **From:** (b) (6) [redacted]
> **Sent:** Monday, April 03, 2017 05:23 PM Eastern Standard Time
> **To:** DJS
> **Subject:** FW: Academic Affiliations SECVA
>
> Sent to (b) (6) [redacted] already
>
> **From:** (b) (6) [redacted] [mailto:(b) (6) [redacted]mssm.edu]
> **Sent:** Monday, April 03, 2017 4:09 PM
> **To:** Shulkin, David J., MD
> **Cc:** (b) (6) [redacted]
> **Subject:** [EXTERNAL] Academic Affiliations SECVA

AMERICAN OVERSIGHT

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To more effectively task those important issues we encourage moving more resource and research decisions to local director leadership instead of centrally, because facility directors are able to make more informed decisions based on availability of local clinical and research expertise and excellence in the local community, academic affiliation, and the VA medical center.

Sincerely,

[redacted]

[redacted]

(b) (6) [redacted] MD

President & CEO,

(b) (6) [redacted] MD

(b) (6) [redacted]

Dean,

AMERICAN OVERSIGHT

Mount Sinai Health System
Mount Sinai

Affairs,

Icahn School of Medicine at

President for Academic

Mount Sinai Health System

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 11:19:07 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Fwd: Academic Affiliations SECVA

Bruce- i just wanted you to be aware - so we coordinate efforts

Im ok if you take the lead

David

Sent from my iPhone

Begin forwarded message:

> **From:** DJS <vacodjs1@va.gov>
> **Date:** April 3, 2017 at 6:58:15 PM EDT
> **To:** 'Shulkin ' <drshulkin@aol.com>
> **Subject: FW: Academic Affiliations SECVA**
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>
> Sent to (b) (6) already
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> ---
>
> **From:** (b) (6) [mailto (b) (6) mssm.edu]
> **Sent:** Monday, April 03, 2017 4:09 PM
> **To:** Shulkin, David J., MD
> **Cc:** (b) (6)
> **Subject:** [EXTERNAL] Academic Affiliations SECVA
>
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>
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AMERICAN OVERSIGHT

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Sincerely,

(b) (6) MD

President & CEO,

Mount Sinai Health System

(b) (6) MD

(b) (6) Dean,

Icahn School of Medicine at Mount Sinai

President for Academic Affairs,

Mount Sinai Health System

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 4/3/2017 3:15:17 PM
To: IP [(b) (6) frenchangel59.com]; Bruce Moskowitz [(b) (6) mac.com]; L Perl [(b) (6) gmail.com]; David shulkin [drshulkin@aol.com]
Subject: Fwd: Thank You

FYI

---------- Message ----------
Date: Mon, Apr 3, 2017 at 11:07 AM
Subject: Thank You
To: "(b) (6) isakson.senate.gov" <(b) (6) isakson.senate.gov>

(b) (6) I waited until today to send this email because I didn't want to disturb your weekend. Again, a special thanks to you for making our meeting happen, and with a big smile, and thanks for passing this on to the Senator. My regards to (b) (6) and, if you don't mind, can you confirm that you received this?

Marc

Senator Isakson

Thank you very much for giving of your time last Thursday to talk about the VA and T(b) (6) I know that you fit that conversation into an otherwise packed day of a one day trip. Some conversations strain to last five minutes and others fly by. Our time flew by, for me anyway. It was one of those conversations that you hope will take place, but so often fails to deliver. This one didn't disappoint. I so hope we can meet again…I would love to pick up the conversation– about the VA and life in general. On both fronts, there is so much to discuss.

I passed our discussion onto the President, including your need to maintain the momentum that Tom has brought to you and the Senate Committee, without any impact to that effort. Your message was clear. My heartfelt wishes for a continued recovery from the surgery. Joan told me that golf is likely not in your near-term plans because of the surgery, but I belong to a top 75 golf course nearby and would enjoy nothing more than the opportunity to spend that time with you enjoying the outdoors with good conversation. Please let me know if that becomes a possibility. It is a standing invitation.

AMERICAN OVERSIGHT

With gratitude, all my best,

Marc

Marc B. Sherman | Managing Director

Alvarez & Marsal

Washington Center | 1001 G Street, NW | Suite 1100, West Tower | Washington, DC 20001

Office 202.729.(b) (6) | Mobile 202.758.(b) (6)

Executive Assistant| (b) (6) |202.729.(b) (6) | (b) (6) @alvarezandmarsal.com

North America + Europe + Latin America + Middle East + Asia

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/2/2017 11:04:01 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: VA And Apple

Absolutely right

Can we get someone to send us the commas plan on this

Sent from my iPad

On Apr 2, 2017, at 5:47 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Wow!! That's the precise reason we have to make sure we continue to include them regularly. You should share the comms plan around release of the Transparency Site that includes talking to congress, 60min and USA Today. I think we get (b) (6) involved with Marc and Bruce so that we can get comments from the Academic Affiliate group incorporated in our messaging.
>
> Remember what I told you- they want to give us there valuable time and support but ensure that they are respected and valued and want to be "in the loop" with constant communication. They are our biggest allies and have confidence in us- but we have to manage the relationship very very carefully and with full attention.
>
> Sent from my iPhone
>
> On Apr 2, 2017, at 8:02 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> > It's easy to get on the wrong side of this group
> >
> > Sent from my iPad
> >
> > Begin forwarded message:
> >
> > **From:** "IP" <(b) (6) frenchangel59.com>
> > **Date:** April 2, 2017 at 10:51:54 AM EDT
> > **To:** "David shulkin" <drshulkin@aol.com>
> > **Subject: FW: VA And Apple**
> >
> > ---
> >
> > **From:** IP [mailto:(b) (6) frenchangel59.com]
> > **Sent:** Sunday, April 02, 2017 10:16 AM
> > **To:** (b) (6) EOP/WHO'
> > **Cc:** 'Kushner, Jared C. EOP/WHO'; (b) (6) EOP/WHO'
> > **Subject:** RE: VA And Apple
> >
> > (b) (6)
> > My email to (b) (6) on Thursday expressed my frustration and displeasure in learning about activity and decisions concerning issues at the VA in a separate and invisible parallel effort. Regrettably, your response to my email that "(b) (6) has

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been working but not communicating" not only fails to recognize or explain the issue, but merely highlights the very fundamental problem that is so troubling. While a lack of communication has certainly exacerbated the problem, the mere fact that there has been any activity or decision without first coordinating that activity with our team before taking any action is the problem. Simply offering to communicate better solves very little. In your and (b) (6) first meeting in the West Wing with Marc Sherman it was clear and agreed that (b) (6) would be the liaison between our expert team and the White House and provide her IT counsel to our team related to our initiatives (not as an invisible, parallel effort). In addition, the White House was to be available to assist our team with executive and legislative clout when requested (not conduct an invisible, parallel effort), a three-pronged approach, if you recall. This is the program I reported to the President and the go-ahead we received.

The essential problem at the VA is that 22 veterans die every day and the system of care and access to care is in need of repair. This is a medical issue and medical delivery problem. In order to fix the VA, these medical problems must first be defined and fixed. All other issues, like IT, are a function of the determined fix to the medical issues and medical delivery problems. To transform the VA into the best of class, I assembled a team that includes the best and brightest minds in the academic medical community. The restructuring efforts on which we embark are informed by the advice and participation of those great medical minds. Parallel (and invisible to us) IT efforts are not connected to what the medical minds decide are the problem or the fix and are frustrating the IT solution that deals with the medical issues. It is also spending the valuable time of volunteers and delaying the best care that our veterans deserve.

Your email to me underscores this problem. You say that:

- "[redacted] efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services," and

- "There is a call on Monday with Apple, the VA, and (b) (6) to review the…status of the EHMP work…[and] to confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities."

However, it is not possible to design an EHMP system or integrate the system with an Apple device until you know how the medical experts are going to change the medical delivery system and how

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they advise a device should be utilized in the medical delivery system. The academic medical experts on our team are assisting the VA in designing a sophisticated system of community care through a public-private delivery system. They are formulating that system and its inner workings, the creation of which will dictate the Integration and interoperability of records. Neither (b) (6) nor Apple can define a scope or product use without consulting with our group on how veteran's records used in the private sector will get integrated into the portable record and back to the VA.

You mention in your email telehealth. Our team of medical experts are working on a telehealth initiative and delivered a draft Executive Order to the President...while you are working with the DEA and DOJ, without the courtesy of advising us, which could have tremendous implications on the wording or, worse yet, the prudence of an Executive Order in the first place. This parallel path as well creates the potential for embarrassment for the President and wasted invaluable time that our veterans can ill afford.

Lastly, you discuss your parallel meeting on a Military Wellness program which you apparently already brought in which you believe focuses on preventative medicine. The program that you are touting however is surrounded by rumors that are less than flattering. Moreover, our team's academic medical experts are already assisting in the active development of a wellness program for the VA and their views will prevail. Those experts have already assembled the working parts of a wellness program and the seamless integration with active service members and family. There is no need to have a parallel side effort that is not integrated into the agreed program. Again, the problem is not about communication.

I had an employee a few years back that meant well but thought that there was an "I" in team. His work for the company created value and profits for the company at various times, however, in spite of those benefits, I advised him that his way was not working and he should find something else that better met his style.

With all this considered, I think that (b) (6) is a smart woman that could provide the VA IT experience and benefits, my way...not as a renegade player. I am willing to work with her as a team player on our team. The expert team that I assembled and is sanctioned by the President will be proceeding with its efforts as planned. All other parallel efforts should stand down. (b) (6) can participate as part of that team, not outside of that team or its efforts or its direction. As agreed on day one, the White House can participate by providing executive and administrative assistance, when requested by our expert team. We will arrange and conduct discussions with Apple (in which (b) (6) should participate if done within the confines of the expert team). We will work with design and implementation of a wellness program and we will decide on

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the proper way to integrate an EMR system, with (b) (6) team participation if agreed. Any items that relate to the transformation of the VA must be funneled through and managed by the expert team and should be coordinated with Dr. Moskowitz and Marc Sherman.
Let me know if you have any questions.
Ike

From: (b) (6) EOP/WHO
[mailto(b) (6) who.eop.gov]
Sent: Friday, March 31, 2017 6:03 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: (b) (6) EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

As we discussed it seems like (b) (6) has been working but not communicating. Her efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services. There is a call on Monday with Apple, the VA, and (b) (6) to review the following:

1. Status of the EHMP work
2. to find a legal mechanism to allow for 3 month tour of duty from Apple engineers with the employees staying on Apple payroll. This is being investigated by USDS lawyers and the VA.
3. To work through an NDA / conflict waiver which is a necessary legal document.
4. To confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities.)

I believe we should then schedule a call for mid next week with Ike, appropriate members of Ike's team, the VA, Apple and (b) (6) myself to ensure we are on same page (I can coordinate the call). I think we should allow (b) (6) an opportunity to reset and to act as a true overall project manager where we allow her to coordinate. She should communicate with Ike and his designee consistently and she should professionally coordinate the team, get everyone working together, and show us

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progress. I believe she will do a great job, and we will know quickly if she does not.

As everyone knows huge other hot items at VA in the works right now including Accountability (legislation and EO), Choice Reform Act extension and reform; telehealth (working through the issue with DOJ and DEA; hard to just slam it through if they oppose but based on meeting today with VA/DOJ/DEA I believe we can get them there in next two weeks. Ike, I can explain in detail when we next talk but having been through this with the Opioid EO this week we should see if we can get DEA / DOJ on board).

Different subject, Ike would also like your advice on NIH and the idea (I think your idea?) to create a profit sharing program with our grants. Love this idea.
Yours truly,
(b) (6)
P.S. I need to update you on very exciting meeting on a Military Wellness program which we brought in; focuses on preventative medicine and is working for over 20,000 vets currently. Readily scalable.

(b) (6)
Assistant to the President
For Intragovernmental and Technology Initiatives
202.456.(b) (6) (Direct)
(b) (6) who.eop.gov

From: IP [mailto:(b) (6) frenchangel59.com]
Sent: Friday, March 31, 2017 12:05 AM
To: Kushner, Jared C. EOP/WHO <(b) (6) who.eop.gov>
Cc: (b) (6) EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Subject: FW: VA And Apple

Jared,

As you know Ivanka introduced me to (b) (6) at Apple and (b) (6) at Johnson & Johnson. Ours Academic team and experts have worked so well with them and their teams. What [redacted] has done here is really outrageous. She may be very good in social media, but this an entirely different and very complicated area.

We will fix this.

AMERICAN OVERSIGHT

All my Best,

Ike

From: IP [mailto:[redacted]frenchangel59.com]
Sent: Thursday, March 30, 2017 11:56 PM
To: [redacted]omb.eop.gov
Cc: [redacted]who.eop.gov; lper[redacted]@gmail.com; brucem[redacted]@mac.com; mbs[redacted]@gmail.com
Subject: FW: VA And Apple

[redacted]

With all due respect, I am shocked and extremely disappointed with the manner in which you have engaged in individual communications with Apple - and intentionally excluded our broader team of subject matter experts. I understand that these backdoor discussions have apparently been occurring almost daily for weeks, and you have not told anyone and refuse to return phone calls and emails.

When we first met on February 7th, I personally shared with you our vision and goals and explained that it is critical that everything we do must be done as a team.

The very purpose of our Academic team, Dr. Moskowitz, and Marc Sherman is to ensure proper analysis, sharing of best practices, and provide a forum for discussion, debate, and ultimately the strongest collective decisions/recommendations.

You agreed then, but your actions to date regarding Apple prove otherwise.

When I spoke with [redacted] on February 1st we discussed and agreed on the importance of leveraging our Academic team and experts for the end goal of creating the best system for our veterans. Further on our Apple conference call on March 3rd - which we invited you and [redacted] to join - we again discussed and all agreed that for us to be successful and fix all the issues that our great veterans are going through on a daily basis, we must all unite and work as one team, with only one agenda and one goal.

What we are seeing from you today is a blatant disregard for that commitment and clear disrespect to everyone involved. You are putting yourself, your own agenda, and your own ego ahead of our veterans. This is unacceptable. There are 22 veterans dying every day. Your decision to alone discuss IT and technology solutions with Apple for weeks without the broader team of experts and not informing me and Dr. Moskowitz is major step backwards and will only cause additional work and significant delays. As a result of your hijacking of this effort, Apple has already canceled conference calls.

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In fact, many of the current problems with the VA is because of this very reason - the lack of team work within. Let me be clear, I will not allow this to happen while I am involved.

I want this resolved immediately. First, you must include Dr. Moskowitz and Marc Sherman on any and all calls or meetings. Additionally, I will formally ask you again to please respect me and our broader group of subject matter experts, and immediately cease individual discussions with Apple and/or any other parties related to the work we have undertaken regarding the VA.

Ike

-----Original Message-----
From: (b) (6) EOP/OMB
[mailto(b) (6) omb.eop.gov]
Sent: Thursday, March 30, 2017 6:48 PM
To: Bruce Moskowitz
Cc: (b) (6) EOP/WHO; IP; (b) (6) frenchangel59.com
Subject: Re: VA And Apple

Hey team! We're making great progress, which I'm excited to fill you in on. Will send you more info when I get out of these back-to-back mtgs and will give you a ring back Ike!

Thanks!

[redacted]

> On Mar 30, 2017, at 6:49 AM, Bruce Moskowitz
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> Sent from my iPad
> Bruce Moskowitz M.D.

-----Original Message-----
From: Bruce Moskowitz [mailto(b) (6) mac.com]
Sent: Tuesday, March 28, 2017 11:41 AM
To: (b) (6) who.eop.gov; (b) (6) omb.eop.gov
Cc: IP
Subject: VA And Apple

It would be of benefit to discuss what we can accomplish in technology with Apple for the benefit of the VA. It would be of importance to understand what discussions the Whitehouse team has already had

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with Apple so that we have a clear path forward and do not duplicate what has already been accomplished. Let me know a convenient time to talk. Thank you

Sent from my iPad
Bruce Moskowitz M.D.

<mime-attachment>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/2/2017 9:47:59 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: VA And Apple

Wow!! That's the precise reason we have to make sure we continue to include them regularly. You should share the comms plan around release of the Transparency Site that includes talking to congress, 60min and USA Today. I think we get (b) (6) involved with Marc and Bruce so that we can get comments from the Academic Affiliate group incorporated in our messaging.

Remember what I told you- they want to give us there valuable time and support but ensure that they are respected and valued and want to be "in the loop" with constant communication. They are our biggest allies and have confidence in us- but we have to manage the relationship very very carefully and with full attention.

Sent from my iPhone

On Apr 2, 2017, at 8:02 PM, David Shulkin <drshulkin@aol.com> wrote:

> It's easy to get on the wrong side of this group
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** "IP" <(b) (6) frenchangel59.com>
> **Date:** April 2, 2017 at 10:51:54 AM EDT
> **To:** "David shulkin" <drshulkin@aol.com>
> **Subject: FW: VA And Apple**
>
> ---
>
> **From:** IP [mailto (b) (6) frenchangel59.com]
> **Sent:** Sunday, April 02, 2017 10:16 AM
> **To:** (b) (6) EOP/WHO'
> **Cc:** 'Kushner, Jared C. EOP/WHO'; (b) (6) EOP/WHO'
> **Subject:** RE: VA And Apple
>
> (b) (6)
> My email to (b) (6) on Thursday expressed my frustration and displeasure in learning about activity and decisions concerning issues at the VA in a separate and invisible parallel effort. Regrettably, your response to my email that "(b) (6) has been working but not communicating" not only fails to recognize or explain the issue, but merely highlights the very fundamental problem that is so troubling. While a lack of communication has certainly exacerbated the problem, the mere fact that there has been any activity or decision without first coordinating that activity with our team before taking any action is the problem. Simply offering to communicate better solves very little.
> In your and (b) (6) first meeting in the West Wing with Marc Sherman it was clear and agreed that (b) (6) would be the liaison between our expert team and the White House and provide her IT counsel to our team related to our initiatives

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(not as an invisible, parallel effort). In addition, the White House was to be available to assist our team with executive and legislative clout when requested (not conduct an invisible, parallel effort), a three-pronged approach, if you recall. This is the program I reported to the President and the go-ahead we received.

The essential problem at the VA is that 22 veterans die every day and the system of care and access to care is in need of repair. This is a medical issue and medical delivery problem. In order to fix the VA, these medical problems must first be defined and fixed. All other issues, like IT, are a function of the determined fix to the medical issues and medical delivery problems. To transform the VA into the best of class, I assembled a team that includes the best and brightest minds in the academic medical community. The restructuring efforts on which we embark are informed by the advice and participation of those great medical minds. Parallel (and invisible to us) IT efforts are not connected to what the medical minds decide are the problem or the fix and are frustrating the IT solution that deals with the medical issues. It is also spending the valuable time of volunteers and delaying the best care that our veterans deserve.

Your email to me underscores this problem. You say that:

- "[redacted] efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services," and

- "There is a call on Monday with Apple, the VA, and (b) (6) to review the…status of the EHMP work…[and] to confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities."

However, it is not possible to design an EHMP system or integrate the system with an Apple device until you know how the medical experts are going to change the medical delivery system and how they advise a device should be utilized in the medical delivery system. The academic medical experts on our team are assisting the VA in designing a sophisticated system of community care through a public-private delivery system. They are formulating that system and its inner workings, the creation of which will dictate the Integration and interoperability of records. Neither (b) (6) nor Apple can define a scope or product use without consulting with our group on how veteran's records used in the private sector will get integrated into the portable record and back to the VA.

You mention in your email telehealth. Our team of medical experts are working on a telehealth initiative and delivered a draft Executive Order to the President...while you are working with the DEA and DOJ, without the courtesy of advising us, which could have tremendous implications on the wording or, worse yet, the prudence of an Executive Order in the first place. This parallel path as well creates the potential for embarrassment for the President and wasted invaluable time that our veterans can ill afford.

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Lastly, you discuss your parallel meeting on a Military Wellness program which you apparently already brought in which you believe focuses on preventative medicine. The program that you are touting however is surrounded by rumors that are less than flattering. Moreover, our team's academic medical experts are already assisting in the active development of a wellness program for the VA and their views will prevail. Those experts have already assembled the working parts of a wellness program and the seamless integration with active service members and family. There is no need to have a parallel side effort that is not integrated into the agreed program. Again, the problem is not about communication.
I had an employee a few years back that meant well but thought that there was an "I" in team. His work for the company created value and profits for the company at various times, however, in spite of those benefits, I advised him that his way was not working and he should find something else that better met his style.
With all this considered, I think that (b) (6) is a smart woman that could provide the VA IT experience and benefits, my way...not as a renegade player. I am willing to work with her as a team player on our team. The expert team that I assembled and is sanctioned by the President will be proceeding with its efforts as planned. All other parallel efforts should stand down. (b) (6) can participate as part of that team, not outside of that team or its efforts or its direction. As agreed on day one, the White House can participate by providing executive and administrative assistance, when requested by our expert team. We will arrange and conduct discussions with Apple (in which (b) (6) should participate if done within the confines of the expert team). We will work with design and implementation of a wellness program and we will decide on the proper way to integrate an EMR system, with (b) (6) team participation if agreed. Any items that relate to the transformation of the VA must be funneled through and managed by the expert team and should be coordinated with Dr. Moskowitz and Marc Sherman.
Let me know if you have any questions.
Ike

From: (b) (6) EOP/WHO [mailto(b) (6) who.eop.gov]
Sent: Friday, March 31, 2017 6:03 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: (b) (6) EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

As we discussed it seems like (b) (6) has been working but not communicating. Her efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services. There is a call on Monday with Apple, the VA, and (b) (6) to review the following:

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Yours truly,

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P.S. I need to update you on very exciting meeting on a Military Wellness program which we brought in; focuses on preventative medicine and is working for over 20,000 vets currently. Readily scalable.

(b) (6)
Assistant to the President
For Intragovernmental and Technology Initiatives

AMERICAN OVERSIGHT

202.456.[b) (6)] (Direct)
[b) (6)] who.eop.gov

From: IP [mailto:[b) (6)] frenchangel59.com]
Sent: Friday, March 31, 2017 12:05 AM
To: Kushner, Jared C. EOP/WHO <[b) (6)] who.eop.gov>
Cc: [b) (6)] EOP/WHO <[b) (6)] who.eop.gov>; [b) (6)] EOP/WHO <[b) (6)] who.eop.gov>
Subject: FW: VA And Apple

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We will fix this.

All my Best,

Ike

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Sent: Thursday, March 30, 2017 11:56 PM
To: [b) (6)] omb.eop.gov
Cc: [b) (6)] who.eop.gov; lper[b) (6)] @gmail.com; brucem[b) (6)] @mac.com; mbs[b) (6)] @gmail.com
Subject: FW: VA And Apple

[b) (6)]

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AMERICAN OVERSIGHT

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Sent: Thursday, March 30, 2017 6:48 PM
To: Bruce Moskowitz
Cc: (b) (6) EOP/WHO; IP; (b) (6) frenchangel59.com
Subject: Re: VA And Apple

Hey team! We're making great progress, which I'm excited to fill you in on. Will send you more info when I get out of these back-to-back mtgs and will give you a ring back Ike!

Thanks!

[redacted]

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Cc: IP

AMERICAN OVERSIGHT

Subject: VA And Apple

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Sent from my iPad
Bruce Moskowitz M.D.

<mime-attachment>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/2/2017 7:17:35 PM
To: IP [(b) (6)frenchangel59.com]
Subject: Re: VA And Apple

Great

Sent from my iPhone

On Apr 2, 2017, at 2:57 PM, IP <(b) (6)frenchangel59.com> wrote:

From: (b) (6) EOP/WHO [mailto(b) (6) who.eop.gov]
Sent: Sunday, April 02, 2017 2:33 PM
To: IP; (b) (6) EOP/WHO
Cc: Kushner, Jared C. EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

Ike and I had a great conversation and are on the same-page.

From: (b) (6) EOP/WHO
Sent: Sunday, April 2, 2017 1:13 PM
To: 'IP' <(b) (6)frenchangel59.com>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Cc: Kushner, Jared C. EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Subject: RE: VA And Apple

Call me anytime

From: IP [mailto(b) (6)frenchangel59.com]
Sent: Sunday, April 2, 2017 1:08 PM
To: (b) (6) EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Cc: Kushner, Jared C. EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Subject: RE: VA And Apple

(b) (6)

Thanks for your email and especially the thoughts on FACA. The good news is that we have been advised that FACA does not apply because we are not a formal group in any way. I have identified, as I mentioned, the brightest medical minds in medical system operations. Each of those people (in their individual capacity) is willing to give of their personal time for the betterment of the VA when requested by the VA. And each of these people has been willing to provide advice to the Secretary when he reaches out to any one of them. I have an understanding of their individual views and could fill you in when we speak since it isn't practical to continue debating any of this on email.

AMERICAN OVERSIGHT

Ike

From: [redacted] EOP/WHO [mailto[redacted]who.eop.gov]
Sent: Sunday, April 02, 2017 11:17 AM
To: IP; [redacted] EOP/WHO
Cc: Kushner, Jared C. EOP/WHO; [redacted] EOP/WHO
Subject: RE: VA And Apple

Ike, you expressed concern in our call the other day that "we were just posing for pictures" in this WH but in the below you seem concerned that we are engaged. You are concerned that we are not communicating but please consider that I do not receive updates from your team.
Please keep in mind that I have nothing but the utmost respect for what you are doing and that I know this is a life-and-death topic. But to do what you outlined below you will need to form a FACA group. One is being formed on Infrastructure. Please have your attorney reach out to WH Counsel [redacted] (copied) to start that process. I have interjected a few thoughts into your email below:

From: IP [mailto[redacted]frenchangel59.com]
Sent: Sunday, April 2, 2017 10:16 AM
To: [redacted] EOP/WHO <[redacted]who.eop.gov>
Cc: Kushner, Jared C. EOP/WHO <[redacted]who.eop.gov>; [redacted] EOP/WHO <[redacted]who.eop.gov>
Subject: RE: VA And Apple

[redacted]

My email to [redacted] on Thursday expressed my frustration and displeasure in learning about activity and decisions concerning issues at the VA in a separate and invisible parallel effort. Regrettably, your response to my email that "[redacted] has been working but not communicating" not only fails to recognize or explain the issue, but merely highlights the very fundamental problem that is so troubling. While a lack of communication has certainly exacerbated the problem, the mere fact that there has been any activity or decision without first coordinating that activity with our team before taking any action is the problem. Simply offering to communicate better solves very little. I AGREE, THAT WAS MY POINT, LACK OF COMMUNICATION. I WAS FOCUSED ON CHANGE MOVING FORWARD NOT GOING BACKWARD.

In your and [redacted] first meeting in the West Wing with Marc Sherman it was clear and agreed that [redacted] would be the liaison between our expert team and the White House and provide her IT counsel to our team related to our initiatives (not as an invisible, parallel effort). In addition, the White House was to be available to assist our team with executive and legislative clout when requested (not conduct an invisible, parallel effort), a three-pronged approach, if you recall. This is the program I reported to the President and the go-ahead we received.

AMERICAN OVERSIGHT

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Your email to me underscores this problem. You say that:

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However, it is not possible to design an EHMP system or integrate the system with an Apple device until you know how the medical experts are going to change the medical delivery system and how they advise a device should be utilized in the medical delivery system. The academic medical experts on our team are assisting the VA in designing a sophisticated system of community care through a public-private delivery system. They are formulating that system and its inner workings, the creation of which will dictate the Integration and interoperability of records. Neither (b) (6) nor Apple can define a scope or product use without consulting with our group on how veteran's records used in the private sector will get integrated into the portable record and back to the VA. RIGHT NOW THERE IS NO MEDICAL DELIVERY SYSTEM THAT CAN ACCESS THE MEDICAL RECORDS. THE EHMP MUST BE COMPLETED TO ALLOW ANY SUCH PRODUCT TO EXTRAPOLATE THE DATA.

You mention in your email telehealth. Our team of medical experts are working on a telehealth initiative and delivered a draft Executive Order to the President...while you are working with the DEA and DOJ, without the courtesy of advising us, which could have tremendous implications on the wording or, worse yet, the prudence of an Executive Order in the first place. This parallel path as well creates the potential for embarrassment for the President and wasted invaluable time that our veterans can ill afford. THIS EO (WHICH IS LIKELY TO BE PART OF A LARGER VA EO) WILL 100% GO THROUGH DOJ AND DEA. IT MAY OR MAY NOT BE POSSIBLE FOR THE PRESIDENT TO SLAM THROUGH AN EO AGAINST THEIR WISHES HOWEVER IT IS FAR BETTER FOR THE PRESIDENT TO REACH CONCENSUS. KEEP IN MIND THERE ARE OVER 50,000 PEOPLE PER YEAR DYING FROM DRUG OVERDOSES MUCH OF WHICH IS LINKIED TO THE OVER-SUBSCRIBING OF OPIOIDS. DEA AND DOJ (I BELIEVE INCORRECTLY) VIEW TELEHEALTH AS A LESSENING OF CONTROL.

AMERICAN OVERSIGHT

Lastly, you discuss your parallel meeting on a Military Wellness program which you apparently already brought in which you believe focuses on preventative medicine. The program that you are touting however is surrounded by rumors that are less than flattering. Moreover, our team's academic medical experts are already assisting in the active development of a wellness program for the VA and their views will prevail. Those experts have already assembled the working parts of a wellness program and the seamless integration with active service members and family. There is no need to have a parallel side effort that is not integrated into the agreed program. Again, the problem is not about communication. THE MILITARY WELLNESS INITIATIVE HAS BEEN LAUDED IN EVERY REVIEW, AND BT THE VA, AND VSO'S. IT IS IN PLACE, THE VA CAN DECIDE TO AMPLIFY ITS EFFORTS OR NOT. IT WOULD IN NO WAY PREVENT THE VA FROM HAVING A MAJOR WELLNESS INITIATIVE OF ITS OWN; IT IS SUPPLEMENTAL. I DO NOT HAVE AN OPINION AS TO WHETHER IT SHOULD BE AMPLIFIED, IT IS SOMETHING FOR THE VA TO DETERMINE.

I had an employee a few years back that meant well but thought that there was an "I" in team. His work for the company created value and profits for the company at various times, however, in spite of those benefits, I advised him that his way was not working and he should find something else that better met his style. I HAD A FEW OF THEM WITH MY 15,000 EMPLOYEES AS WELL!

With all this considered, I think that (b) (6) is a smart woman that could provide the VA IT experience and benefits, my way...not as a renegade player. I am willing to work with her as a team player on our team. The expert team that I assembled and is sanctioned by the President will be proceeding with its efforts as planned. All other parallel efforts should stand down. (b) (6) can participate as part of that team, not outside of that team or its efforts or its direction. As agreed on day one, the White House can participate by providing executive and administrative assistance, when requested by our expert team. We will arrange and conduct discussions with Apple (in which (b) (6) should participate if done within the confines of the expert team). We will work with design and implementation of a wellness program and we will decide on the proper way to integrate an EMR system, with (b) (6) team participation if agreed. Any items that relate to the transformation of the VA must be funneled through and managed by the expert team and should be coordinated with Dr. Moskowitz and Marc Sherman. SHE CANNOT REPORT TO NON-GOVERNMENT PEOPLE.

Let me know if you have any questions. AS I EMAILED SOME OF THE BIGGEST ISSUES FOR THE VA RIGHT NOW ARE LEGISLATIVE. THE ACCOUNTABILITY ACT, THE EXTENSION OF THE CHOICE ACT, THE CHOICE REFORM ACT (AND THE CORRESPONDING BUDGET ISSUES RAISED BY ALLOWING CHOICE)

Ike

From: (b) (6) EOP/WHO [mailto (b) (6) who.eop.gov]
Sent: Friday, March 31, 2017 6:03 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: (b) (6) EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

AMERICAN OVERSIGHT

As we discussed it seems like [redacted] has been working but not communicating. Her efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services. There is a call on Monday with Apple, the VA, and [redacted] to review the following:

1. Status of the EHMP work
2. to find a legal mechanism to allow for 3 month tour of duty from Apple engineers with the employees staying on Apple payroll. This is being investigated by USDS lawyers and the VA.
3. To work through an NDA / conflict waiver which is a necessary legal document.
4. To confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities.)

I believe we should then schedule a call for mid next week with Ike, appropriate members of Ike's team, the VA, Apple and [redacted] myself to ensure we are on same page (I can coordinate the call). I think we should allow [redacted] an opportunity to reset and to act as a true overall project manager where we allow her to coordinate. She should communicate with Ike and his designee consistently and she should professionally coordinate the team, get everyone working together, and show us progress. I believe she will do a great job, and we will know quickly if she does not.

As everyone knows huge other hot items at VA in the works right now including Accountability (legislation and EO), Choice Reform Act extension and reform; telehealth (working through the issue with DOJ and DEA; hard to just slam it through if they oppose but based on meeting today with VA/DOJ/DEA I believe we can get them there in next two weeks. Ike, I can explain in detail when we next talk but having been through this with the Opioid EO this week we should see if we can get DEA / DOJ on board).

Different subject, Ike would also like your advice on NIH and the idea (I think your idea?) to create a profit sharing program with our grants. Love this idea.
Yours truly,
[redacted]

P.S. I need to update you on very exciting meeting on a Military Wellness program which we brought in; focuses on preventative medicine and is working for over 20,000 vets currently. Readily scalable.

[redacted]

AMERICAN OVERSIGHT

Assistant to the President
For Intragovernmental and Technology Initiatives
202.456.[redacted] (Direct)
[redacted]who.eop.gov

From: IP [mailto:[redacted]frenchangel59.com]
Sent: Friday, March 31, 2017 12:05 AM
To: Kushner, Jared C. EOP/WHO <[redacted]who.eop.gov>
Cc: [redacted] EOP/WHO <[redacted]who.eop.gov>; [redacted] EOP/WHO <[redacted]who.eop.gov>
Subject: FW: VA And Apple

Jared,

As you know Ivanka introduced me to [redacted] at Apple and [redacted] at Johnson & Johnson. Ours Academic team and experts have worked so well with them and their teams. What [redacted] has done here is really outrageous. She may be very good in social media, but this an entirely different and very complicated area.

We will fix this.

All my Best,

Ike

From: IP [mailto:[redacted]frenchangel59.com]
Sent: Thursday, March 30, 2017 11:56 PM
To: [redacted]omb.eop.gov
Cc: [redacted]who.eop.gov; lper[redacted]@gmail.com; brucem[redacted]@mac.com; mbs[redacted]@gmail.com
Subject: FW: VA And Apple

[redacted]

With all due respect, I am shocked and extremely disappointed with the manner in which you have engaged in individual communications with Apple - and intentionally excluded our broader team of subject matter experts. I understand that these backdoor discussions have apparently been occurring almost daily for weeks, and you have not told anyone and refuse to return phone calls and emails.

When we first met on February 7th, I personally shared with you our vision and goals and explained that it is critical that everything we do must be done as a team.

The very purpose of our Academic team, Dr. Moskowitz, and Marc Sherman is to ensure proper analysis, sharing of best practices, and provide a forum for discussion, debate, and ultimately the strongest collective decisions/recommendations.

You agreed then, but your actions to date regarding Apple prove otherwise.

When I spoke with [redacted] on February 1st we discussed and agreed on the importance of leveraging our Academic team and experts for the end goal of creating the best system for our veterans. Further on our Apple conference call on March 3rd - which we invited you and [redacted] to join - we again discussed and all agreed that for us to be successful and fix all the issues that our great veterans are going through on a daily basis, we must all unite and work as one team, with only one agenda and one goal.

AMERICAN OVERSIGHT

What we are seeing from you today is a blatant disregard for that commitment and clear disrespect to everyone involved. You are putting yourself, your own agenda, and your own ego ahead of our veterans. This is unacceptable. There are 22 veterans dying every day. Your decision to alone discuss IT and technology solutions with Apple for weeks without the broader team of experts and not informing me and Dr. Moskowitz is major step backwards and will only cause additional work and significant delays. As a result of your hijacking of this effort, Apple has already canceled conference calls.

In fact, many of the current problems with the VA is because of this very reason - the lack of team work within. Let me be clear, I will not allow this to happen while I am involved.

I want this resolved immediately. First, you must include Dr. Moskowitz and Marc Sherman on any and all calls or meetings. Additionally, I will formally ask you again to please respect me and our broader group of subject matter experts, and immediately cease individual discussions with Apple and/or any other parties related to the work we have undertaken regarding the VA.

Ike

-----Original Message-----
From: (b) (6) EOP/OMB [mailto:(b) (6) omb.eop.gov]
Sent: Thursday, March 30, 2017 6:48 PM
To: Bruce Moskowitz
Cc: (b) (6) EOP/WHO; IP; (b) (6) frenchangel59.com
Subject: Re: VA And Apple

Hey team! We're making great progress, which I'm excited to fill you in on. Will send you more info when I get out of these back-to-back mtgs and will give you a ring back Ike!

Thanks!

[redacted]

> On Mar 30, 2017, at 6:49 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> In the last email exchange i was supposed to receive information on your interaction with Apple so that we could rapidly obtain needed technology from our Academic Center Consortium upcoming discussion with Apple. I realize there are multiple technology issues on everyone's desk however we have medical emergencies daily at the VA that can only be solved by rapid deployment of new technology. I am available 24-7 by phone 561-3466(b) (6) Thank you
>
> Sent from my iPad
> Bruce Moskowitz M.D.

-----Original Message-----
From: Bruce Moskowitz [mailto:(b) (6) mac.com]
Sent: Tuesday, March 28, 2017 11:41 AM
To: (b) (6) who.eop.gov; (b) (6) omb.eop.gov
Cc: IP
Subject: VA And Apple

It would be of benefit to discuss what we can accomplish in technology with Apple for the benefit of the VA. It would be of importance to understand what discussions the Whitehouse team has already had

AMERICAN OVERSIGHT

with Apple so that we have a clear path forward and do not duplicate what has already been accomplished. Let me know a convenient time to talk. Thank you

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/2/2017 7:02:20 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: VA And Apple
Attachments: Untitled Attachment; Untitled attachment 05945.htm

It's easy to get on the wrong side of this group

Sent from my iPad

Begin forwarded message:

> **From:** "IP" <(b) (6) frenchangel59.com>
> **Date:** April 2, 2017 at 10:51:54 AM EDT
> **To:** "David shulkin" <drshulkin@aol.com>
> **Subject: FW: VA And Apple**
>
> ---
>
> **From:** IP [mailto(b) (6) frenchangel59.com]
> **Sent:** Sunday, April 02, 2017 10:16 AM
> **To:** (b) (6) EOP/WHO'
> **Cc:** 'Kushner, Jared C. EOP/WHO'; (b) (6) EOP/WHO'
> **Subject:** RE: VA And Apple
>
> (b) (6)
>
> My email to (b) (6) on Thursday expressed my frustration and displeasure in learning about activity and decisions concerning issues at the VA in a separate and invisible parallel effort. Regrettably, your response to my email that "(b) (6) has been working but not communicating" not only fails to recognize or explain the issue, but merely highlights the very fundamental problem that is so troubling. While a lack of communication has certainly exacerbated the problem, the mere fact that there has been any activity or decision without first coordinating that activity with our team before taking any action is the problem. Simply offering to communicate better solves very little.
>
> In your and (b) (6) first meeting in the West Wing with Marc Sherman it was clear and agreed that (b) (6) would be the liaison between our expert team and the White House and provide her IT counsel to our team related to our initiatives (not as an invisible, parallel effort). In addition, the White House was to be available to assist our team with executive and legislative clout when requested (not conduct an invisible, parallel effort), a three-pronged approach, if you recall. This is the program I reported to the President and the go-ahead we received.
>
> The essential problem at the VA is that 22 veterans die every day and the system of care and access to care is in need of repair. This is a medical issue and medical delivery problem. In order to fix the VA, these medical problems must first be defined and fixed. All other issues, like IT, are a function of the determined fix to the medical issues and medical delivery problems. To transform the VA into the best of class, I assembled a team that includes the best and brightest minds in the academic medical community. The restructuring efforts on which

AMERICAN OVERSIGHT

we embark are informed by the advice and participation of those great medical minds. Parallel (and invisible to us) IT efforts are not connected to what the medical minds decide are the problem or the fix and are frustrating the IT solution that deals with the medical issues. It is also spending the valuable time of volunteers and delaying the best care that our veterans deserve.

Your email to me underscores this problem. You say that:

- "[redacted] efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services," and

- "There is a call on Monday with Apple, the VA, and (b) (6) to review the…status of the EHMP work…[and] to confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities."

However, it is not possible to design an EHMP system or integrate the system with an Apple device until you know how the medical experts are going to change the medical delivery system and how they advise a device should be utilized in the medical delivery system. The academic medical experts on our team are assisting the VA in designing a sophisticated system of community care through a public-private delivery system. They are formulating that system and its inner workings, the creation of which will dictate the Integration and interoperability of records. Neither (b) (6) nor Apple can define a scope or product use without consulting with our group on how veteran's records used in the private sector will get integrated into the portable record and back to the VA.

You mention in your email telehealth. Our team of medical experts are working on a telehealth initiative and delivered a draft Executive Order to the President...while you are working with the DEA and DOJ, without the courtesy of advising us, which could have tremendous implications on the wording or, worse yet, the prudence of an Executive Order in the first place. This parallel path as well creates the potential for embarrassment for the President and wasted invaluable time that our veterans can ill afford.

Lastly, you discuss your parallel meeting on a Military Wellness program which you apparently already brought in which you believe focuses on preventative medicine. The program that you are touting however is surrounded by rumors that are less than flattering. Moreover, our team's academic medical experts are already assisting in the active development of a wellness program for the VA and their views will prevail. Those experts have already assembled the working parts of a wellness program and the seamless integration with active service members and family. There is no need to have a parallel side effort that is not integrated into the agreed program. Again, the problem is not about communication.

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AMERICAN OVERSIGHT

With all this considered, I think that [redacted] is a smart woman that could provide the VA IT experience and benefits, my way...not as a renegade player. I am willing to work with her as a team player on our team. The expert team that I assembled and is sanctioned by the President will be proceeding with its efforts as planned. All other parallel efforts should stand down. [redacted] can participate as part of that team, not outside of that team or its efforts or its direction. As agreed on day one, the White House can participate by providing executive and administrative assistance, when requested by our expert team. We will arrange and conduct discussions with Apple (in which [redacted] should participate if done within the confines of the expert team). We will work with design and implementation of a wellness program and we will decide on the proper way to integrate an EMR system, with [redacted] team participation if agreed. Any items that relate to the transformation of the VA must be funneled through and managed by the expert team and should be coordinated with Dr. Moskowitz and Marc Sherman.

Let me know if you have any questions.

Ike

From: [redacted] EOP/WHO [mailto[redacted]who.eop.gov]
Sent: Friday, March 31, 2017 6:03 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: [redacted] EOP/WHO; [redacted] EOP/WHO
Subject: RE: VA And Apple

As we discussed it seems like [redacted] has been working but not communicating. Her efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services. There is a call on Monday with Apple, the VA, and [redacted] to review the following:

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AMERICAN OVERSIGHT

consistently and she should professionally coordinate the team, get everyone working together, and show us progress. I believe she will do a great job, and we will know quickly if she does not.

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Yours truly,
(b) (6)

P.S. I need to update you on very exciting meeting on a Military Wellness program which we brought in; focuses on preventative medicine and is working for over 20,000 vets currently. Readily scalable.

(b) (6)
Assistant to the President
For Intragovernmental and Technology Initiatives
202.456.(b) (6) (Direct)
(b) (6) who.eop.gov

From: IP [mailto:(b) (6) frenchangel59.com]
Sent: Friday, March 31, 2017 12:05 AM
To: Kushner, Jared C. EOP/WHO <(b) (6) who.eop.gov>
Cc: (b) (6) EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Subject: FW: VA And Apple

Jared,

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We will fix this.

All my Best,

Ike

AMERICAN OVERSIGHT

From: IP [mailto:[redacted]frenchangel59.com]
Sent: Thursday, March 30, 2017 11:56 PM
To: [redacted]omb.eop.gov
Cc: [redacted]who.eop.gov; lper[redacted]@gmail.com; brucem[redacted]@mac.com; mbs[redacted]@gmail.com
Subject: FW: VA And Apple

[redacted]

With all due respect, I am shocked and extremely disappointed with the manner in which you have engaged in individual communications with Apple - and intentionally excluded our broader team of subject matter experts. I understand that these backdoor discussions have apparently been occurring almost daily for weeks, and you have not told anyone and refuse to return phone calls and emails.

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You agreed then, but your actions to date regarding Apple prove otherwise.

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What we are seeing from you today is a blatant disregard for that commitment and clear disrespect to everyone involved. You are putting yourself, your own agenda, and your own ego ahead of our veterans. This is unacceptable. There are 22 veterans dying every day. Your decision to alone discuss IT and technology solutions with Apple for weeks without the broader team of experts and not informing me and Dr. Moskowitz is major step backwards and will only cause additional work and significant delays. As a result of your hijacking of this effort, Apple has already canceled conference calls.

In fact, many of the current problems with the VA is because of this very reason - the lack of team work within. Let me be clear, I will not allow this to happen while I am involved.

I want this resolved immediately. First, you must include Dr. Moskowitz and Marc Sherman on any and all calls or meetings. Additionally, I will formally ask you again to please respect me and our broader group of subject matter experts, and immediately cease individual discussions with Apple and/or any other parties related to the work we have undertaken regarding the VA.

Ike

-----Original Message-----
From: [redacted] EOP/OMB [mailto:[redacted]omb.eop.gov]
Sent: Thursday, March 30, 2017 6:48 PM
To: Bruce Moskowitz
Cc: [redacted] EOP/WHO; IP; [redacted]frenchangel59.com
Subject: Re: VA And Apple

AMERICAN OVERSIGHT

Hey team! We're making great progress, which I'm excited to fill you in on. Will send you more info when I get out of these back-to-back mtgs and will give you a ring back Ike!

Thanks!

[redacted]

> On Mar 30, 2017, at 6:49 AM, Bruce Moskowitz <(b) (6) [redacted]mac.com> wrote:
>
> In the last email exchange i was supposed to receive information on your interaction with Apple so that we could rapidly obtain needed technology from our Academic Center Consortium upcoming discussion with Apple. I realize there are multiple technology issues on everyone's desk however we have medical emergencies daily at the VA that can only be solved by rapid deployment of new technology. I am available 24-7 by phone 561-3466(b) (6) [redacted] Thank you
>
> Sent from my iPad
> Bruce Moskowitz M.D.

-----Original Message-----
From: Bruce Moskowitz [mailto:(b) (6) [redacted]mac.com]
Sent: Tuesday, March 28, 2017 11:41 AM
To: (b) (6) [redacted]who.eop.gov; (b) (6) [redacted]omb.eop.gov
Cc: IP
Subject: VA And Apple

It would be of benefit to discuss what we can accomplish in technology with Apple for the benefit of the VA. It would be of importance to understand what discussions the Whitehouse team has already had with Apple so that we have a clear path forward and do not duplicate what has already been accomplished. Let me know a convenient time to talk. Thank you

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: [redacted] EOP/WHO [[redacted]who.eop.gov]
Sent: 4/1/2017 12:40:55 PM
To: Kushner, Jared C. EOP/WHO [[redacted]who.eop.gov]; [redacted]frenchangel59.com

To follow up on my email of yesterday (and this may not need clarifying) but I am suggesting we give [redacted] a chance to project manage the IT component only. And that we quickly ascertain if she is up to it.
Obvi the VA needs a great CIO. [redacted] USDS has sourced and interviewed 4 candidates and reviewed w David., he has asked 3 to come in to meet with him. (Ike, Jared said you might have a great person from Cleveland Clinic that would get on team for a period of time? That would be incredible).

Two other hot items: met w Shulkin and OMB. Shulkin believes he will need additional $7.5B in 2018 budget to offer the Choice option (part of Choice reform legislation being considered). He had some ideas how to achieve (charging Medicare) but all have issues, OMB is going to consider and get back to us.

I arranged and David is preparing for meeting w Sec Mattis and DOD senior staff on the myriad of coordination issues. Need to force it but there is ability to make huge progress there.
Sent from my iPad

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: IP [(b) (6) frenchangel59.com]
Sent: 4/2/2017 5:10:25 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: VA And Apple

From: IP [mailto:(b) (6) frenchangel59.com]
Sent: Sunday, April 02, 2017 1:08 PM
To: (b) (6) EOP/WHO'; (b) (6) EOP/WHO'
Cc: 'Kushner, Jared C. EOP/WHO'; (b) (6) EOP/WHO'
Subject: RE: VA And Apple

(b) (6)

Thanks for your email and especially the thoughts on FACA. The good news is that we have been advised that FACA does not apply because we are not a formal group in any way. I have identified, as I mentioned, the brightest medical minds in medical system operations. Each of those people (in their individual capacity) is willing to give of their personal time for the betterment of the VA when requested by the VA. And each of these people has been willing to provide advice to the Secretary when he reaches out to any one of them. I have an understanding of their individual views and could fill you in when we speak since it isn't practical to continue debating any of this on email.

Ike

From: (b) (6) EOP/WHO [mailto:(b) (6) who.eop.gov]
Sent: Sunday, April 02, 2017 11:17 AM
To: IP; (b) (6) EOP/WHO
Cc: Kushner, Jared C. EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

Ike, you expressed concern in our call the other day that "we were just posing for pictures" in this WH but in the below you seem concerned that we are engaged. You are concerned that we are not communicating but please consider that I do not receive updates from your team. Please keep in mind that I have nothing but the utmost respect for what you are doing and that I know this is a life-and-death topic. But to do what you outlined below you will need to form a FACA group. One is being formed on Infrastructure. Please have your attorney reach out to WH Counsel (b) (6) (copied) to start that process. I have interjected a few thoughts into your email below:

From: IP [mailto:(b) (6) frenchangel59.com]
Sent: Sunday, April 2, 2017 10:16 AM
To: (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Cc: Kushner, Jared C. EOP/WHO <(b) (6) who.eop.gov>; (b) (6) EOP/WHO <(b) (6) who.eop.gov>
Subject: RE: VA And Apple

(b) (6)

AMERICAN OVERSIGHT

My email to [redacted] on Thursday expressed my frustration and displeasure in learning about activity and decisions concerning issues at the VA in a separate and invisible parallel effort. Regrettably, your response to my email that "[redacted] has been working but not communicating" not only fails to recognize or explain the issue, but merely highlights the very fundamental problem that is so troubling. While a lack of communication has certainly exacerbated the problem, the mere fact that there has been any activity or decision without first coordinating that activity with our team before taking any action is the problem. Simply offering to communicate better solves very little. I AGREE, THAT WAS MY POINT, LACK OF COMMUNICATION. I WAS FOCUSED ON CHANGE MOVING FORWARD NOT GOING BACKWARD.

In your and [redacted] first meeting in the West Wing with Marc Sherman it was clear and agreed that [redacted] would be the liaison between our expert team and the White House and provide her IT counsel to our team related to our initiatives (not as an invisible, parallel effort). In addition, the White House was to be available to assist our team with executive and legislative clout when requested (not conduct an invisible, parallel effort), a three-pronged approach, if you recall. This is the program I reported to the President and the go-ahead we received.

The essential problem at the VA is that 22 veterans die every day and the system of care and access to care is in need of repair. This is a medical issue and medical delivery problem. In order to fix the VA, these medical problems must first be defined and fixed. All other issues, like IT, are a function of the determined fix to the medical issues and medical delivery problems. To transform the VA into the best of class, I assembled a team that includes the best and brightest minds in the academic medical community. The restructuring efforts on which we embark are informed by the advice and participation of those great medical minds. Parallel (and invisible to us) IT efforts are not connected to what the medical minds decide are the problem or the fix and are frustrating the IT solution that deals with the medical issues. It is also spending the valuable time of volunteers and delaying the best care that our veterans deserve.

Your email to me underscores this problem. You say that:

- "[redacted] efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services," and

- "There is a call on Monday with Apple, the VA, and [redacted] to review the...status of the EHMP work...[and] to confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities."

However, it is not possible to design an EHMP system or integrate the system with an Apple device until you know how the medical experts are going to change the medical delivery system and how they advise a device should be utilized in the medical delivery system. The academic medical experts on our team are assisting the VA in designing a sophisticated system of community care through a public-private delivery system. They are formulating that system and its inner workings, the creation of which will dictate the Integration and interoperability of records. Neither [redacted] nor Apple can define a scope or product use without consulting with our group on how veteran's records used in the private sector will get integrated into the portable record and back to the VA. RIGHT NOW THERE IS NO MEDICAL DELIVERY SYSTEM THAT CAN ACCESS THE MEDICAL RECORDS. THE EHMP MUST BE COMPLETED TO ALLOW ANY SUCH PRODUCT TO EXTRAPOLATE THE DATA.

You mention in your email telehealth. Our team of medical experts are working on a telehealth initiative and delivered a draft Executive Order to the President...while you are working with the DEA and DOJ, without the

AMERICAN OVERSIGHT

courtesy of advising us, which could have tremendous implications on the wording or, worse yet, the prudence of an Executive Order in the first place. This parallel path as well creates the potential for embarrassment for the President and wasted invaluable time that our veterans can ill afford. THIS EO (WHICH IS LIKELY TO BE PART OF A LARGER VA EO) WILL 100% GO THROUGH DOJ AND DEA. IT MAY OR MAY NOT BE POSSIBLE FOR THE PRESIDENT TO SLAM THROUGH AN EO AGAINST THEIR WISHES HOWEVER IT IS FAR BETTER FOR THE PRESIDENT TO REACH CONCENSUS. KEEP IN MIND THERE ARE OVER 50,000 PEOPLE PER YEAR DYING FROM DRUG OVERDOSES MUCH OF WHICH IS LINKIED TO THE OVER-SUBSCRIBING OF OPIOIDS. DEA AND DOJ (I BELIEVE INCORRECTLY) VIEW TELEHEALTH AS A LESSENING OF CONTROL.

Lastly, you discuss your parallel meeting on a Military Wellness program which you apparently already brought in which you believe focuses on preventative medicine. The program that you are touting however is surrounded by rumors that are less than flattering. Moreover, our team's academic medical experts are already assisting in the active development of a wellness program for the VA and their views will prevail. Those experts have already assembled the working parts of a wellness program and the seamless integration with active service members and family. There is no need to have a parallel side effort that is not integrated into the agreed program. Again, the problem is not about communication. THE MILITARY WELLNESS INITIATIVE HAS BEEN LAUDED IN EVERY REVIEW, AND BT THE VA, AND VSO'S. IT IS IN PLACE, THE VA CAN DECIDE TO AMPLIFY ITS EFFORTS OR NOT. IT WOULD IN NO WAY PREVENT THE VA FROM HAVING A MAJOR WELLNESS INITIATIVE OF ITS OWN; IT IS SUPPLEMENTAL. I DO NOT HAVE AN OPINION AS TO WHETHER IT SHOULD BE AMPLIFIED, IT IS SOMETHING FOR THE VA TO DETERMINE.

I had an employee a few years back that meant well but thought that there was an "I" in team. His work for the company created value and profits for the company at various times, however, in spite of those benefits, I advised him that his way was not working and he should find something else that better met his style. I HAD A FEW OF THEM WITH MY 15,000 EMPLOYEES AS WELL!

With all this considered, I think that (b) (6) is a smart woman that could provide the VA IT experience and benefits, my way...not as a renegade player. I am willing to work with her as a team player on our team. The expert team that I assembled and is sanctioned by the President will be proceeding with its efforts as planned. All other parallel efforts should stand down. (b) (6) can participate as part of that team, not outside of that team or its efforts or its direction. As agreed on day one, the White House can participate by providing executive and administrative assistance, when requested by our expert team. We will arrange and conduct discussions with Apple (in which (b) (6) should participate if done within the confines of the expert team). We will work with design and implementation of a wellness program and we will decide on the proper way to integrate an EMR system, with (b) (6) team participation if agreed. Any items that relate to the transformation of the VA must be funneled through and managed by the expert team and should be coordinated with Dr. Moskowitz and Marc Sherman. SHE CANNOT REPORT TO NON-GOVERNMENT PEOPLE.

Let me know if you have any questions. AS I EMAILED SOME OF THE BIGGEST ISSUES FOR THE VA RIGHT NOW ARE LEGISLATIVE. THE ACCOUNTABILITY ACT, THE EXTENSION OF THE CHOICE ACT, THE CHOICE REFORM ACT (AND THE CORRESPONDING BUDGET ISSUES RAISED BY ALLOWING CHOICE)

Ike

From: (b) (6) EOP/WHO [mailto(b) (6) who.eop.gov]
Sent: Friday, March 31, 2017 6:03 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: (b) (6) EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

AMERICAN OVERSIGHT

As we discussed it seems like [redacted] has been working but not communicating. Her efforts have been focused with the VA on ensuring that an EHMP is completed above their health records so that the medical records can be pulled into an Apple device. The EHMP work is in process and is a necessity for Apple to then come in and provide its services. There is a call on Monday with Apple, the VA, and [redacted] to review the following:

1. Status of the EHMP work
2. to find a legal mechanism to allow for 3 month tour of duty from Apple engineers with the employees staying on Apple payroll. This is being investigated by USDS lawyers and the VA.
3. To work through an NDA / conflict waiver which is a necessary legal document.
4. To confirm Apple job scope which includes portability of health records / data from VA to Apple products; VA technical changes to how to allow VA workers to use Apple products; (and potentially portability of health records / data to non-VA medical facilities.)

I believe we should then schedule a call for mid next week with Ike, appropriate members of Ike's team, the VA, Apple and [redacted] myself to ensure we are on same page (I can coordinate the call). I think we should allow [redacted] an opportunity to reset and to act as a true overall project manager where we allow her to coordinate. She should communicate with Ike and his designee consistently and she should professionally coordinate the team, get everyone working together, and show us progress. I believe she will do a great job, and we will know quickly if she does not.

As everyone knows huge other hot items at VA in the works right now including Accountability (legislation and EO), Choice Reform Act extension and reform; telehealth (working through the issue with DOJ and DEA; hard to just slam it through if they oppose but based on meeting today with VA/DOJ/DEA I believe we can get them there in next two weeks. Ike, I can explain in detail when we next talk but having been through this with the Opioid EO this week we should see if we can get DEA / DOJ on board).

Different subject, Ike would also like your advice on NIH and the idea (I think your idea?) to create a profit sharing program with our grants. Love this idea.

Yours truly,

[redacted]

P.S. I need to update you on very exciting meeting on a Military Wellness program which we brought in; focuses on preventative medicine and is working for over 20,000 vets currently. Readily scalable.

[redacted]
Assistant to the President
For Intragovernmental and Technology Initiatives
202.456.[redacted] (Direct)
[redacted]who.eop.gov

AMERICAN OVERSIGHT

From: IP [mailto:[redacted]frenchangel59.com]
Sent: Friday, March 31, 2017 12:05 AM
To: Kushner, Jared C. EOP/WHO <[redacted]who.eop.gov>
Cc: [redacted] EOP/WHO <[redacted]who.eop.gov>; [redacted] EOP/WHO <[redacted]who.eop.gov>
Subject: FW: VA And Apple

Jared,

As you know Ivanka introduced me to [redacted] at Apple and [redacted] at Johnson & Johnson. Ours Academic team and experts have worked so well with them and their teams. What [redacted] has done here is really outrageous. She may be very good in social media, but this an entirely different and very complicated area.

We will fix this.

All my Best,

Ike

From: IP [mailto:[redacted]frenchangel59.com]
Sent: Thursday, March 30, 2017 11:56 PM
To: [redacted]omb.eop.gov
Cc: [redacted]who.eop.gov; lper[redacted]@gmail.com; brucem[redacted]@mac.com; mbs[redacted]@gmail.com
Subject: FW: VA And Apple

[redacted]

With all due respect, I am shocked and extremely disappointed with the manner in which you have engaged in individual communications with Apple - and intentionally excluded our broader team of subject matter experts. I understand that these backdoor discussions have apparently been occurring almost daily for weeks, and you have not told anyone and refuse to return phone calls and emails.

When we first met on February 7th, I personally shared with you our vision and goals and explained that it is critical that everything we do must be done as a team.

The very purpose of our Academic team, Dr. Moskowitz, and Marc Sherman is to ensure proper analysis, sharing of best practices, and provide a forum for discussion, debate, and ultimately the strongest collective decisions/recommendations.

You agreed then, but your actions to date regarding Apple prove otherwise.

When I spoke with [redacted] on February 1st we discussed and agreed on the importance of leveraging our Academic team and experts for the end goal of creating the best system for our veterans. Further on our Apple conference call on March 3rd - which we invited you and [redacted] to join - we again discussed and all agreed that for us to be successful and fix all the issues that our great veterans are going through on a daily basis, we must all unite and work as one team, with only one agenda and one goal.

What we are seeing from you today is a blatant disregard for that commitment and clear disrespect to everyone involved. You are putting yourself, your own agenda, and your own ego ahead of our veterans. This is unacceptable. There are 22 veterans dying every day. Your decision to alone discuss IT and technology solutions with Apple for weeks without the broader team of experts and not informing me and Dr. Moskowitz is major step backwards and will only cause additional work and significant delays. As a result of your hijacking of this effort, Apple has already canceled conference calls.

AMERICAN OVERSIGHT

In fact, many of the current problems with the VA is because of this very reason - the lack of team work within. Let me be clear, I will not allow this to happen while I am involved.

I want this resolved immediately. First, you must include Dr. Moskowitz and Marc Sherman on any and all calls or meetings. Additionally, I will formally ask you again to please respect me and our broader group of subject matter experts, and immediately cease individual discussions with Apple and/or any other parties related to the work we have undertaken regarding the VA.

Ike

-----Original Message-----
From: (b) (6) EOP/OMB [mailto:(b) (6) omb.eop.gov]
Sent: Thursday, March 30, 2017 6:48 PM
To: Bruce Moskowitz
Cc: (b) (6) EOP/WHO; IP; (b) (6) frenchangel59.com
Subject: Re: VA And Apple

Hey team! We're making great progress, which I'm excited to fill you in on. Will send you more info when I get out of these back-to-back mtgs and will give you a ring back Ike!

Thanks!

[redacted]

> On Mar 30, 2017, at 6:49 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
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> In the last email exchange i was supposed to receive information on your interaction with Apple so that we could rapidly obtain needed technology from our Academic Center Consortium upcoming discussion with Apple. I realize there are multiple technology issues on everyone's desk however we have medical emergencies daily at the VA that can only be solved by rapid deployment of new technology. I am available 24-7 by phone 561-3466 (b) (6) Thank you
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> Sent from my iPad
> Bruce Moskowitz M.D.

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From: Bruce Moskowitz [mailto:(b) (6) mac.com]
Sent: Tuesday, March 28, 2017 11:41 AM
To: (b) (6) who.eop.gov; (b) (6) omb.eop.gov
Cc: IP
Subject: VA And Apple

It would be of benefit to discuss what we can accomplish in technology with Apple for the benefit of the VA. It would be of importance to understand what discussions the Whitehouse team has already had with Apple so that we have a clear path forward and do not duplicate what has already been accomplished. Let me know a convenient time to talk. Thank you

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Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 4/2/2017 2:51:54 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: VA And Apple
Attachments: Untitled Attachment

From: IP [mailto:(b) (6)frenchangel59.com]
Sent: Sunday, April 02, 2017 10:16 AM
To: (b) (6) EOP/WHO'
Cc: 'Kushner, Jared C. EOP/WHO'; (b) (6) EOP/WHO'
Subject: RE: VA And Apple

(b) (6)

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AMERICAN OVERSIGHT

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Let me know if you have any questions.

Ike

AMERICAN OVERSIGHT

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Sent: Friday, March 31, 2017 6:03 PM
To: IP; Kushner, Jared C. EOP/WHO
Cc: (b) (6) EOP/WHO; (b) (6) EOP/WHO
Subject: RE: VA And Apple

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P.S. I need to update you on very exciting meeting on a Military Wellness program which we brought in; focuses on preventative medicine and is working for over 20,000 vets currently. Readily scalable.

AMERICAN OVERSIGHT

(b) (6)
Assistant to the President
For Intragovernmental and Technology Initiatives
202.456.(b) (6) (Direct)
(b) (6) who.eop.gov

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Sent: Friday, March 31, 2017 12:05 AM
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Cc: (b) (6) who.eop.gov; lper(b) (6) @gmail.com; brucem(b) (6) @mac.com; mbs(b) (6) @gmail.com
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AMERICAN OVERSIGHT

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Ike

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Sent: Thursday, March 30, 2017 6:48 PM
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Subject: Re: VA And Apple

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Thanks!

[redacted]

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AMERICAN OVERSIGHT

Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: [redacted] EOP/WHO [[redacted]who.eop.gov]
Sent: 4/1/2017 12:40:55 PM
To: Kushner, Jared C. EOP/WHO [[redacted]who.eop.gov]; [redacted]frenchangel59.com

To follow up on my email of yesterday (and this may not need clarifying) but I am suggesting we give [redacted] a chance to project manage the IT component only. And that we quickly ascertain if she is up to it.
Obvi the VA needs a great CIO. [redacted] USDS has sourced and interviewed 4 candidates and reviewed w David., he has asked 3 to come in to meet with him. (Ike, Jared said you might have a great person from Cleveland Clinic that would get on team for a period of time? That would be incredible).

Two other hot items: met w Shulkin and OMB. Shulkin believes he will need additional $7.5B in 2018 budget to offer the Choice option (part of Choice reform legislation being considered). He had some ideas how to achieve (charging Medicare) but all have issues, OMB is going to consider and get back to us.

I arranged and David is preparing for meeting w Sec Mattis and DOD senior staff on the myriad of coordination issues. Need to force it but there is ability to make huge progress there.
Sent from my iPad

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/12/2017 1:39:51 AM
To: (b) (6) [(b) (6) mayo.edu]
CC: David Shulkin [drshulkin@aol.com]; Marc Sherman [(b) (6) gmail.com]; brucem(b) (6) @mac.com
Subject: Fwd: FYI | Follow-up: VA Public-facing Web site

Sensitivity: Company Confidential

Chris- on behalf of the secretary and the VA, I want to thank you for your support. Your leadership in rallying the other academic centers and your strategic advice has been invaluable. We are really excited about tomorrow when we go-live! This is new turn for us as we embark upon our transformation journey together.

Marc- good catching up today- looking forward to dinner next week

Sent from my iPhone

Begin forwarded message:

From: "(b) (6) <(b) (6) mayo.edu>
Date: April 11, 2017 at 2:44:20 PM EDT
To: "Poonam Alaigh ((b) (6) hotmail.com)" <(b) (6) hotmail.com>
Cc: "(b) (6) ((b) (6) gmail.com)" <(b) (6) gmail.com>
Subject: FYI | Follow-up: VA Public-facing Web site

From: (b) (6)
Sent: Tuesday, April 11, 2017 1:44 PM
To: (b) (6) (b) (6) va.gov
Cc: (b) (6) (b) (6) (b) (6) ((b) (6) gmail.com)
Subject: Follow-up: VA Public-facing Web site
Sensitivity: Confidential

Hi – thanks (b) (6) connecting you w/ (b) (6) at the VA....

From: (b) (6) [mailto:(b) (6) jhmi.edu]
Sent: Tuesday, April 11, 2017 1:20 PM
To: (b) (6)
Cc: (b) (6) (b) (6)
Subject: MORE | Your Input: VA Public-facing Web site
Sensitivity: Confidential

Hello, (b) (6)

I spoke with (b) (6) about this and we have reached out to Dr. (b) (6) senior vice president of patient safety and quality and he has agreed to speak about this.

(b) (6)

(b) (6)
Executive Assistant to SVP
Marketing & Communications, JHM
901 S. Bond Street, Baltimore, MD 21231
P: 410-955-(b) (6)
F: 410-955-(b) (6)

AMERICAN OVERSIGHT

From: [b) (6) [mailto[b) (6) mayo.edu]
Sent: Tuesday, April 11, 2017 1:34 PM
To: [b) (6) <[b) (6) PARTNERS.ORG>; [b) (6)
<[b) (6) mayo.edu>; [b) (6) [b) (6) mayo.edu>; [b) (6)
[b) (6) @PARTNERS.ORG>; [b) (6) [b) (6) @jhmi.edu>; [b) (6) ccf.org; [b) (6)
<[b) (6) jhu.edu>; [b) (6) ([b) (6) ccf.org) <[b) (6) ccf.org>; [b) (6)
[b) (6) @PARTNERS.ORG>; [b) (6) kp.org; [b) (6) kp.org; [b) (6)
[b) (6) @mayo.edu>; [b) (6) [b) (6) @mayo.edu>; [b) (6)
[b) (6) @mayo.edu>
Subject: MORE | Your Input: VA Public-facing Web site
Sensitivity: Confidential

Hi – sharing an additional update from the team at the VA:

- The site will not be active outside of the VA firewall until late early tomorrow morning. However, the VA team is finalizing a video that walks people through the site. Will have that for you as soon as it is finished and online.
- The VA team is "most interested" in your CEO; or someone you designate in your organization (perhaps a Quality lead; or "digital care/web" lead be open to speaking w/ the news media, sharing perspective on how this reflects a step forward for veterans and reflects what patients are seeking from healthcare providers?
- The VA team would also welcome our organizations sharing this on our various social media platforms.
- Would you also consider sharing a "heads up" to your local/regional medical/health reporters – encouraging coverage.
- The VA team would is also exploring a "day three" story about this – Dr. Shulkin had a "sit down/exclusive" w/ USA Today (story will hit tomorrow); possibilities they are exploring include an extended conversation w/ a designated reporter that would pair Dr. Shulkin w/ one of the academic partner CEOs (think National Public Radio, or another outlet); or possibly an op-ed submission. Again, focus would be on sharing perspective on how this reflects a step forward for veterans and reflects what patients are seeking from healthcare providers.

Let me know of your interest in participating in the above – in follow-up, will link you directly w/ [b) (6) the VA Communications "point."

Thanks, [b) (6)

From: [b) (6)
Sent: Monday, April 10, 2017 4:59 PM
To: [b) (6) [b) (6) [b) (6) [b) (6) [b) (6)
[b) (6) ccf.org; [b) (6) jhu.edu; [b) (6) ([b) (6) ccf.org); [b) (6)
[b) (6) kp.org; [b) (6) kp.org; [b) (6) [RO PA]; [b) (6) [b) (6)
Subject: URGENT | Your Input: VA Public-facing Web site
Sensitivity: Confidential

PLEASE TREAT AS BUSINESS CONFIDENTIAL

AMERICAN OVERSIGHT

Hi – on Wednesday, the VA will announce a web site designed for Veterans to make informed decisions about where they receive their health care. The overview of the plan and the project objectives are attached.

Dr. Bruce Moskowitz routed the plan in late March to the CEO of the five academic medical center organizations, encouraging that the CEOs "express support/confidence" in the plan. Several CEOs expressed in follow-up emails that they would be willing to "voice support for the approach, that it's reflective of the direction the VA needs to move to best support the care of veterans, etc."

Dr. Poonam Alaigh, VA Acting Under Secretary for Health, Dr. Moskowitz and I spoke late this afternoon – the question: as this rolls out (going public on Wednesday), would your CEO; or someone you designate in your organization (perhaps a Quality lead; or "digital care/web" lead be open to speaking w/ the news media, sharing perspective on how this reflects a step forward for veterans and reflects what patients are seeking from healthcare providers? If not someone from your organization, would you recommend an industry expert that can talk to these issues w/ news media?

The timeline for this would be tomorrow (Tuesday) or Wednesday, as this news goes public.

Thanks for your consideration.

(b) (6)
Chair | Mayo Clinic Department of Public Affairs
200 First Street S.W. | Rochester, MN 55905
cell: 507.269.(b) (6) | office: 507.284.(b) (6)
e-mail: (b) (6) mayo.edu

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/2/2017 6:46:30 PM
To: Va David [vacodjs1@va.gov]
Subject: Fwd: Medical Student Proposal for VA system
Attachments: Osteopathic _Training in The VA.docx; Untitled attachment 05981.htm

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) gmail.com>
Date: April 2, 2017 at 2:00:26 PM EDT
To: David shulkin <drshulkin@aol.com>
Subject: Fwd: Medical Student Proposal for VA system

From: (b) (6) <(b) (6) gmail.com>
Subject: Medical Student Proposal for VA system
Date: April 2, 2017 at 1:52:30 PM EDT
Cc: Poonam Alaigh <(b) (6) hotmail.com>, "(b) (6) DO, MPH, FACOFP dist." <(b) (6) aol.com>

Dear David,

Hope all is well with you and that you are adjusting to your new whirlwind life in D.C.

Commensurate with my brief discussion to you last month I have been working with (b) (6) who will likely represent the American Osteopathic Association and their subgroups in a proposal I wanted to send to you in its raw form. I spoke to Poonam at the banquet about it briefly so I am copying her on the proposal (b) (6) and I wrote . If you want to wait for its final form you don't have to read it, but if you read it and either you or Poonam have any thoughts , any and all changes to form and content are welcome.

Be Well and as always , it was great to see you in NJ

(b) (6)

(b) (6) DO FACOI,FASVM

Associate Professor Internal Medicine

AMERICAN OVERSIGHT

Medical Director Vascular Technology Training program

Rutgers School of Medicine

Attending Gagnon Heart Center

Director Anticoagulation Service

Morristown Medical Center

Morristown ,N.J

AMERICAN OVERSIGHT

Osteopathic Training in The VA System

Since the Advent of the Viet Nam war Osteopathic Physicians have played an increasingly important role in the Military healthcare system with Physicians Enlistees participating in a progressively disproportionate responsibility for healthcare for our serviceman and women in the United States.

The Profession takes great pride in our military and the sacrifices they have made. In this, the American Osteopathic Association feels strongly we should play a role vital in the health care of the armed forces, and also with those who serve if in their times to follow.

Medical students provide a hearty source of academic posture which vitalize their staff counterparts and enhance patient care and patient experience. The role of a medical student thus is thus not parasitic but symbiotic.

The last decade has found American trained students in an increasingly contracted healthcare academic delivery environment.

Our proposal would be to arrange an academic, contractual relationship with the VA System on a national scale which would provide high level Medical students, all of whom have completed Part I of the boards and who would engage in the VA system as a Whole.

We would agree to provide students from around the United States and would be responsible for their presence, behavior, and provide a uniform platform upon which their training would commence.

AMERICAN OVERSIGHT

Given the distinction in governance of the Osteopathic profession as an organization, with regard to its relationship to their colleges of medicine, an agreement could be crafted which would provide a fixed and constant workforce minimal or no cost.

We would provide a number of students of which we would agree, and they would be at their posts each month and a schedule would be applied which would include on call, the appropriate number of patients which would benefit the patient population, and enhance the workload experience of the VA personnel. We will apply established standards to mitigate against undue burdens on both sides.

Our hope would be a relationship which will provide high level staffing for patients in a time of fiscal contraction. Our fervent belief is that setting will provide the students with a lifelong understanding of both the medical problems which are many times unique and the dynamic issues which Veterans face.

We provide students arrange transportation in potentially all 50 states. Taken on a large scale; there could be between 1000 and 2500 OMS rotating/month at a VA institutions.

Rotations could be set up in internal medicine, psychiatry and/or addiction medicine as well as others, depending upon the programs in place at the individual VA. We will need to further discuss details of housing etc. If It Is available this would greatly enhance the programing and facilitate an seamless start to the program.

We should also add aside from the basic platform an elective program for students who wish to do other rotations

AMERICAN OVERSIGHT

we can ask for all VA institutions to partner with our COMs.

The VA has been noted to profound need of primary care physicians.

The Colleges of Osteopathic Medicine are in need of training slots for 3rd and 4th year osteopathic medical students (OMS). Those OMS are primary care oriented and could eventually feed the workforce need of the VA.

This would provide a mutually synergistic aim: to provide quality healthcare to VA patients and quality rotations to OMS, and potentially seed the next generation of physicians into the VA.

We would arrange for AOIA to coordinate these rotations and would take complete responsibility for their actions .

The rotations would be guaranteed by all COMs participating and we will provide continuous monitoring for the VA institutions.

References

1

Osteopathic physicians for military service: hearing before the Committee on Military Affairs. 65th Cong, 2nd sess (1918) (testimony of George W. Riley, DO).

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3

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4

Willard A. Where our students come from. *J Am Osteopath Assoc*. 1947;*46*:313.

Clinical Care • In FY 2011, 70 percent of VA physicians (20,527) had a faculty appointment at a U.S. medical school.2 • In FY 2012, AAMC-member VA teaching hospitals (37 percent of all VA hospitals) accounted for 50 percent of the total admissions at all VA hospitals, 51 percent of the total inpatient days, and 49 percent of the emergency visits. They also performed 41 percent of the total surgeries at VA hospitals.3 • In FY 2007, the Veterans Health Administration reported 669 noncompetitive clinical sharing agreements (i.e., sole source contracts) with affiliated institutions, including medical schools and teaching hospitals, to provide care for veterans outside of the VA valued at $575 million.4 Research With an annual budget of nearly $590 million,5 the VA Office of Research and Development sponsors veteran-centric research

AMERICAN OVERSIGHT

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VA researchers have joint appointments at VA hospitals and medical schools. Recent studies include: •

Sophisticated VA-invented eye- tracking tests to determine a method that could provide physicians with a simpler and more accurate way to diagnose Parkinson's disease. •

A recent VA-sponsored trial for a drug that provided relief for veterans from Operations Iraqi Freedom, Enduring Freedom, and New Dawn who were suffering from nightmares. •

The Million Veteran Program, which was launched in 2011 to recruit a million veterans to collect data on genetics, lifestyle, and health. This information will help clinicians better understand how genetic factors contribute to conditions like post-traumatic stress disorder and traumatic brain injury.

1 FY2015 VA Budget Submission Volume 11 Medical Programs and Information Technology Programs, http://www.va.gov/budget/docs/summary/Fy2015-VolumeII-MedicalProgramsAndInformationTechnology.pdf 2

Annual Report of Residency Training Programs (ARRTP) database, estimate provided by the VA Office of Academic Associations (OAA) 3 AAMC Data Book:

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(b) (6) [redacted] D.O., MPH, FACOFP

(b) (6) [redacted] D.O. FACOI, FSVM

AMERICAN OVERSIGHT

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/2/2017 6:46:19 PM
To: (b) (6) [(b) (6) gmail.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Medical Student Proposal for VA system

(b) (6) - we will get out acadmic affiliations group involved-

Thanks for pulling this together

David

Sent from my iPhone

On Apr 2, 2017, at 2:00 PM, (b) (6) <(b) (6) gmail.com> wrote:

From: (b) (6) <(b) (6) gmail.com>
Subject: Medical Student Proposal for VA system
Date: April 2, 2017 at 1:52:30 PM EDT
Cc: Poonam Alaigh <(b) (6) hotmail.com>, "(b) (6) DO, MPH, FACOFP dist." <(b) (6) aol.com>

Dear David,

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<Osteopathic :Training in The VA.docx>

AMERICAN OVERSIGHT

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Sent: 4/2/2017 6:00:26 PM
To: David shulkin [drshulkin@aol.com]
Subject: Fwd: Medical Student Proposal for VA system
Attachments: Osteopathic _Training in The VA.docx; Untitled attachment 05988.htm

From: [redacted] <[redacted]gmail.com>
Subject: Medical Student Proposal for VA system
Date: April 2, 2017 at 1:52:30 PM EDT
Cc: Poonam Alaigh <[redacted]hotmail.com>, "[redacted] DO, MPH, FACOFP dist." <[redacted]aol.com>

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AMERICAN OVERSIGHT

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Medical Schools and Teaching Hospitals by the Numbers 4 2008 Office of Inspector General (OIG) Audit of VHA Noncompetitive Clinical Sharing Agreements 5 Friends of VA Medical Care and Health Research Recommendations for FY2015, http://www.friendsofva.org/ resources/2014/2015fovarecommendations.pdf.

(b) (6) [redacted] D.O., MPH, FACOFP

(b) (6) [redacted] D.O. FACOI, FSVM

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 12:24:11 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: (b) (6)

Great

Sent from my iPhone

> On Apr 8, 2017, at 8:15 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Spoke to him last night and he has initial interest- will speak to him in more details next week
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/8/2017 12:15:52 PM
To: David Shulkin [drshulkin@aol.com]
Subject: (b) (6)

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Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 11:29:50 PM
To: (b) (6) [(b) (6) gmail.com]

Can we ask our team to track down the clip from cbs evening news tonight that ran on VA

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: bruce moskowitz [(b) (6) gmail.com]
Sent: 4/1/2017 5:03:29 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]
Subject: Re: UPDATED VERSION

Amazing that it takes a case
Like this to get it done
Sent from my iPhone

On Apr 1, 2017, at 12:24 PM, David shulkin <Drshulkin@aol.com> wrote:

> Im taking an unusual and aggressive stance to push for accountability legislation using this outrageous case. I had to fight my lawyers to do this. Already congress has released a statement of support fir my position and Fox news wants a live interview Sunday morning- see the release below
>
> <Press Release - Accountability Final Draft-jeh (3).docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/1/2017 4:24:18 PM
To: brucem(b) (6) @gmail.com; Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]
Subject: Fwd: UPDATED VERSION
Attachments: Press Release - Accountability Final Draft-jeh (3).docx; Untitled attachment 06027.htm

Im taking an unusual and aggressive stance to push for accountability legislation using this outrageous case. I had to fight my lawyers to do this. Already congress has released a statement of support fir my position and Fox news wants a live interview Sunday morning- see the release below

AMERICAN OVERSIGHT

VA | U.S. Department of Veterans Affairs

News Release

Office of Public Affairs
Media Relations

Washington, DC 20420
(202) 461-7600
www.va.gov

FOR IMMEDIATE RELEASE
March 31, 2017

VA Forced to Delay Removing Employee Caught Watching Pornography

VA Supports Congress's Effort to Change Legislation to Expedite Process

WASHINGTON – After a through internal review of an employee of the Michael DeBakey Veterans Affairs Medical Center in Houston was caught watching porn while with a patient, the designated proposing official recommended removal from federal service.

The VA immediately removed the Veteran in question from patient care and placed on administrative duties. Due to current law, the deciding official cannot affect a final determination for 30 days from the date the proposal for removal was made. VA is committed to ensuring every employee retains their right to due process while at the same time reducing the time it takes to remove employees who have engaged in misconduct.

"This is an example of why we need accountability legislation as soon as possible," said Secretary of Veterans Affairs David J. Shulkin. "It's unacceptable that VA has to wait 30 days to act on a proposed removal."

Under current law, the Department of Veterans Affairs (VA) must continue to pay employees who are in the process of being removed. During this advance notice period, at least 30 days from the date that the employee's removal has been proposed, assuming there is no evidence that the employee has committed a crime, an employee must be paid. If the employee has been assessed as a potential danger to Veterans, the employee should be placed on administrative leave with pay. If the employee does not pose an immediate threat to Veterans, they are typically placed on administrative duties, which limits their contact with Veterans and their families while ensuring that they aren't sitting at home collecting a pay check without providing any services to the government.

VA is grateful that Congress has made this a priority. VA has been working with Congress to ensure any legislation would provide VA the ability to expedite removals while still preserving an employee's right to due process. Without these legislative changes, VA will continue to be forced to delay immediate actions to remove employees from federal service.

"Current legislation in Congress reduces the amount of time we have to wait before taking action," continued Secretary Shulkin. "I look forward to working with both the Senate and the House to ensure final legislation gives us the flexibility we need."

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) [redacted]@gmail.com]
Sent: 4/9/2017 8:28:02 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: TEDVA Talk

Thanks, most people would not get it by just looking at the slides, that is why I have to walk them through it.

Darin

On Sun, Apr 9, 2017 at 1:17 PM, David shulkin <Drshulkin@aol.com> wrote:
I didnt appreciate how this model achieved the goals- brilliant

Sent from my iPhone

Begin forwarded message:

> **From:** Darin Selnick <(b) (6) [redacted]@gmail.com>
> **Date:** April 8, 2017 at 6:44:27 PM EDT
> **To:** David shulkin <Drshulkin@aol.com>
> **Subject: TEDVA Talk**
>
> Hi David
>
> Attached are the two slides from my TEDVA talk. The second slide answers the questions on how the VHA providers, as a purely providers group, can get all of the OHI $ just like a Cleveland Clinic can, including the Federal (Medicare, Medicaid and TRICARE).
>
> Key is to have VHA internally fully separate the payer and provider functions and then have Congress designate the provider function as a Federal ACO. That way the $ follows the veteran patients, and the VHA provider has contracts with all OHI and VHA payer. Using this method the eligibility issue goes away since VHA providers are paid for all services from all payers, including all Federal. VHA providers have to become efficient since they have to run their operations on the same payer reimbursement payments as the private sector like Cleveland Clinic gets. For VAMCs that have extra capacity, they can take non-eligible veterans and family members since they are getting full reimbursement from their Health Insurance.
>
> Just my out of the box thinking, key is the legislation which at the same time we can ask for legislative relief on Government regulations on personnel, contracting, acquisition, and other items we identify that stop us from being competitive with the private sector. Time to level the playing field.
>
> Darin

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/9/2017 8:18:58 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: TEDVA Talk
Attachments: VA TED Talk 2.pptx; Untitled attachment 06063.htm; VA TED Talk 2.pptx; Untitled attachment 06066.htm

Tommorow on your way down look at this

Its actually pretty smart

We may need to tweak it- but starting a new business line might be the key to billing medicare

Sent from my iPhone

Begin forwarded message:

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> Just my out of the box thinking, key is the legislation which at the same time we can ask for legislative relief on Government regulations on personnel, contracting, acquisition, and other items we identify that stop us from being competitive with the private sector. Time to level the playing field.
>
> Darin

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$ Follows the Veteran + Federal ACO + Board of Directors











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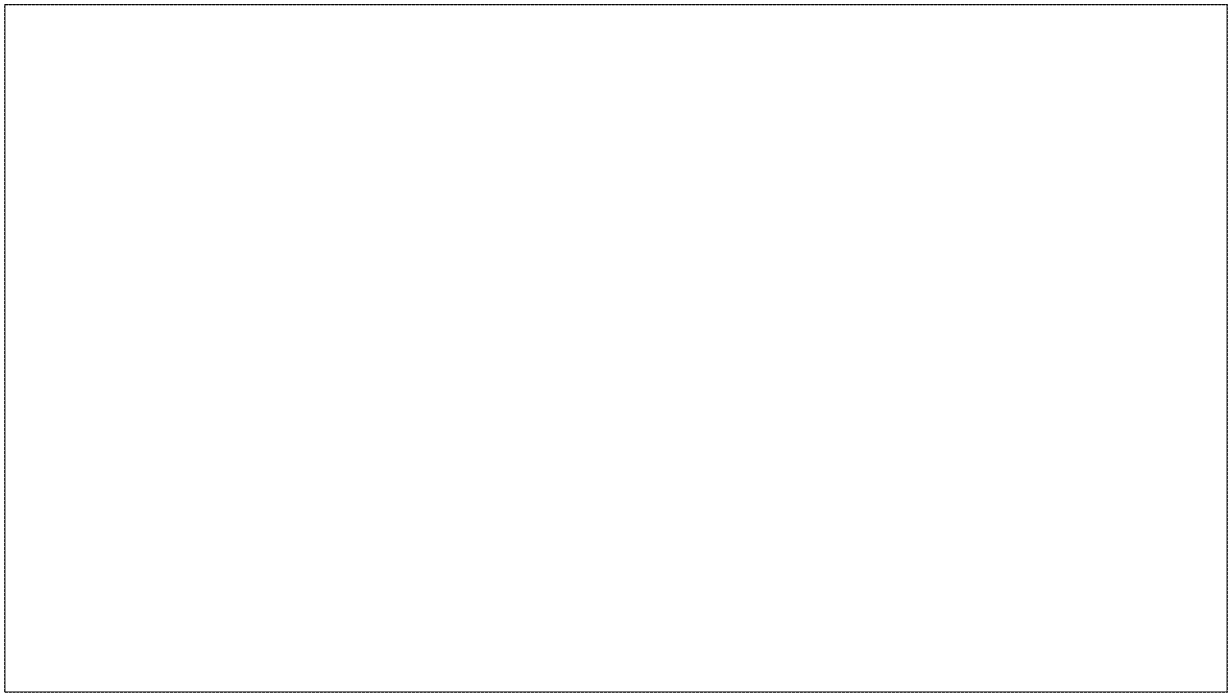

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/9/2017 8:17:31 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: TEDVA Talk
Attachments: VA TED Talk 2.pptx; Untitled attachment 06071.htm; VA TED Talk 2.pptx; Untitled attachment 06074.htm

Sent from my iPhone

Begin forwarded message:

From: Darin Selnick <(b) (6) [redacted]@gmail.com>
Date: April 8, 2017 at 6:44:27 PM EDT
To: David shulkin <Drshulkin@aol.com>
Subject: TEDVA Talk

Hi David

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To: Darin Selnick [(b) (6) @gmail.com]
Subject: Fwd: TEDVA Talk
Attachments: VA TED Talk 2.pptx; Untitled attachment 06079.htm; VA TED Talk 2.pptx; Untitled attachment 06082.htm

I didnt appreciate how this model achieved the goals- brilliant

Sent from my iPhone

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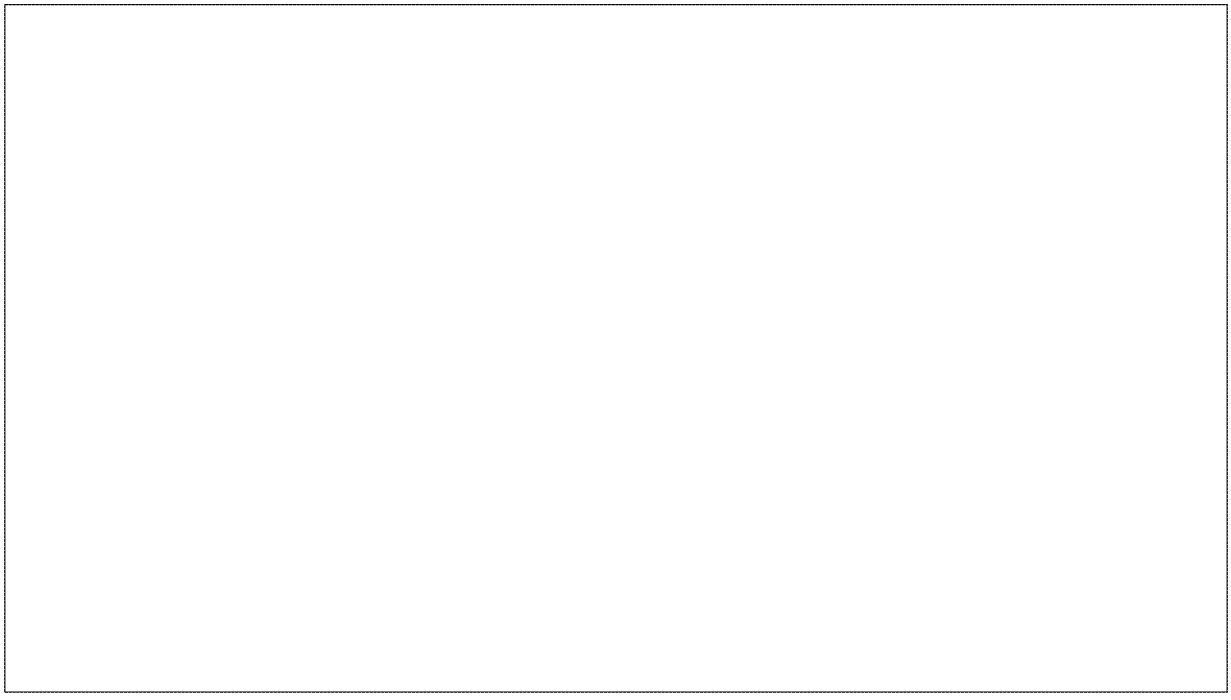

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Message

From: [redacted] [redacted]gmail.com]
Sent: 4/11/2017 9:10:44 PM
To: Bruce Moskowitz [redacted]mac.com]
CC: David Shulkin [drshulkin@aol.com]
Subject: Re: Pacemaker

Good afternoon,

Yes, there are national contracts that individual medical centers can use to order to orthopedic implantables and neuro implantables.

Here are just a few names of the national contracts:

Zimmer
Smith & Nephew
Biomet orthopedics
Depuy orthopedics

On Tue, Apr 11, 2017 at 4:46 PM [redacted] <[redacted]gmail.com> wrote:
Yes checking for you now

On Tue, Apr 11, 2017 at 4:45 PM Bruce Moskowitz <[redacted]mac.com> wrote:
We are referring to orthopedic and neuro

Sent from my iPhone

> On Apr 11, 2017, at 4:39 PM, [redacted] <[redacted]gmail.com> wrote:
>
> Hi Dr. Moskowitz,
>
> On behalf of Dr. Shulkin, we have a national pacemaker contract, each medical center individually orders off of that national contract.
>
> [redacted]

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> --

> Sent from Gmail Mobile

--
Sent from Gmail Mobile
--
Sent from Gmail Mobile

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 8:26:39 PM
To: Jennifer Lee [(b) (6) gmail.com]
Subject: This is your idea

https://www.meritalk.com/the-situation-report-is-the-cio-job-at-va-about-to-lose-its-influence/

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 3/31/2017 4:16:00 AM
To: David shulkin [drshulkin@aol.com]
Subject: FW: VA And Apple

From: IP [mailto(b) (6)frenchangel59.com]
Sent: Friday, March 31, 2017 12:05 AM
To: (b) (6) who.eop.gov
Cc: (b) (6) who.eop.gov; [redacted] (b) EOP/WHO'
Subject: FW: VA And Apple

Jared,

As you know Ivanka introduced me to (b) (6) at Apple and (b) (6) at Johnson & Johnson. Ours Academic team and experts have worked so well with them and their teams. What [redacted] has done here is really outrageous. She may be very good in social media, but this an entirely different and very complicated area.

We will fix this.

All my Best,

Ike

From: IP [mailto(b) (6)frenchangel59.com]
Sent: Thursday, March 30, 2017 11:56 PM
To: (b) (6) omb.eop.gov
Cc: (b) (6) who.eop.gov; lper(b) (6) @gmail.com; brucem(b) (6) @mac.com; mbs(b) (6) @gmail.com
Subject: FW: VA And Apple

(b) (6)

With all due respect, I am shocked and extremely disappointed with the manner in which you have engaged in individual communications with Apple - and intentionally excluded our broader team of subject matter experts. I understand that these backdoor discussions have apparently been occurring almost daily for weeks, and you have not told anyone and refuse to return phone calls and emails.

When we first met on February 7th, I personally shared with you our vision and goals and explained that it is critical that everything we do must be done as a team.

The very purpose of our Academic team, Dr. Moskowitz, and Marc Sherman is to ensure proper analysis, sharing of best practices, and provide a forum for discussion, debate, and ultimately the strongest collective decisions/recommendations.

You agreed then, but your actions to date regarding Apple prove otherwise.

When I spoke with (b) (6) on February 1st we discussed and agreed on the importance of leveraging our Academic team and experts for the end goal of creating the best system for our veterans. Further on our Apple conference call on March 3rd - which we invited you and (b) (6) to join - we again discussed and all agreed that for us to be successful and fix all the issues that our great veterans are going through on a daily basis, we must all unite and work as one team, with only one agenda and one goal.

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What we are seeing from you today is a blatant disregard for that commitment and clear disrespect to everyone involved. You are putting yourself, your own agenda, and your own ego ahead of our veterans. This is unacceptable. There are 22 veterans dying every day. Your decision to alone discuss IT and technology solutions with Apple for weeks without the broader team of experts and not informing me and Dr. Moskowitz is major step backwards and will only cause additional work and significant delays. As a result of your hijacking of this effort, Apple has already canceled conference calls.

In fact, many of the current problems with the VA is because of this very reason - the lack of team work within. Let me be clear, I will not allow this to happen while I am involved.

I want this resolved immediately. First, you must include Dr. Moskowitz and Marc Sherman on any and all calls or meetings. Additionally, I will formally ask you again to please respect me and our broader group of subject matter experts, and immediately cease individual discussions with Apple and/or any other parties related to the work we have undertaken regarding the VA.

Ike

-----Original Message-----
From: (b) (6) EOP/OMB [mailto:(b) (6) omb.eop.gov]
Sent: Thursday, March 30, 2017 6:48 PM
To: Bruce Moskowitz
Cc: (b) (6) EOP/WHO; IP; (b) (6) frenchangel59.com
Subject: Re: VA And Apple

Hey team! We're making great progress, which I'm excited to fill you in on. Will send you more info when I get out of these back-to-back mtgs and will give you a ring back Ike!

Thanks!

[redacted]

> On Mar 30, 2017, at 6:49 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> In the last email exchange i was supposed to receive information on your interaction with Apple so that we could rapidly obtain needed technology from our Academic Center Consortium upcoming discussion with Apple. I realize there are multiple technology issues on everyone's desk however we have medical emergencies daily at the VA that can only be solved by rapid deployment of new technology. I am available 24-7 by phone 561-3466(b) (6) Thank you
>
> Sent from my iPad
> Bruce Moskowitz M.D.

-----Original Message-----
From: Bruce Moskowitz [mailto:(b) (6) mac.com]
Sent: Tuesday, March 28, 2017 11:41 AM
To: (b) (6) who.eop.gov; (b) (6) omb.eop.gov
Cc: IP
Subject: VA And Apple

It would be of benefit to discuss what we can accomplish in technology with Apple for the benefit of the VA. It would be of importance to understand what discussions the Whitehouse team has already had with Apple so that we have a clear path forward and do not duplicate what has already been accomplished. Let me know a convenient time to talk. Thank you

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Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 12:51:49 AM
To: Darin Selnick [(b) (6) [redacted]@gmail.com]
Subject: Re: CVA Support of your statement today

Thanks

Sent from my iPhone

On Apr 2, 2017, at 7:14 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:

> Good job on Fox and Friends today. I received some feedback from people who saw it who said you did well. Your effort is working on changing the narrative, as per this article from daily caller.
>
> http://dailycaller.com/2017/04/02/va-secretary-backs-major-legislation-to-fire-incompetent-corrupt-employees-in-historic-move/
>
> Besides fox and friends, I understand a lot of Republican members read the Daily Caller, so it will be interesting to see how much movement we get this week. Bottom line, public, veterans and VA staff know you are serious about accountability and that is important and a win.
>
> Darin
>
> On Sat, Apr 1, 2017 at 12:31 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:
> Great, happy to assist.
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> On Sat, Apr 1, 2017 at 12:22 PM, David shulkin <Drshulkin@aol.com> wrote:
> I like this idea
>
> Up until now I wasnt sure who could do this but i agree
>
> Sent from my iPhone
>
> On Apr 1, 2017, at 3:15 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:
>
> > Just a thought, as part of being proactive with the press we could have both an internal and external surrogate program in order to drive our VA narrative.
> >
> > That is what we did at VA and why CVA is in the media so much.
> >
> > Internally we can have besides you, a few trusted senior staff to meet with the media, they can be trained. Externally we can people like Newt Gingrich. We all would have talking points so we drive our message.
> >
> > For example on this story, I could have gone on Fox and Friends as your surrogate. I did this all the time at CVA and was on a number of Fox shows and CNN. I can do again if you want in the future.
> >
> > Something to explore with your new Asst Sec OPIA and WH.

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Darin

On Sat, Apr 1, 2017 at 6:22 AM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:
Will do

On Sat, Apr 1, 2017 at 5:08 AM, David shulkin <Drshulkin@aol.com> wrote:
This is really great to see

Please thank them on behalf of all of us at the Department

Sent from my iPhone

On Mar 31, 2017, at 10:50 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:

> FYI
>
> I thought you would want to see the CVA statement supporting you. Starting Monday they will be pushing on Senate members to move the bill.
>
> Darin
>
> ---------- Forwarded message ----------
> From: **CVA - Press** <press@cv4a.org>
> Date: Fri, Mar 31, 2017 at 5:35 PM
> Subject: Unable to Quickly Fire Porn-Watching Employee, VA Secretary Demands Accountability Legislation Is Taken Up
> To: (b) (6) [redacted]@gmail.com
>
> **For Immediate Release:** March 31, 2017
> **Media Contact:** press@cv4a.org

CONCERNED VETERANS FOR AMERICA

Unable to Quickly Fire Porn-Watching Employee, VA Secretary Demands

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Accountability Legislation Is Taken Up

Arlington, VA – After the Department of Veterans Affairs (VA) failed to quickly remove an employee caught watching pornography with a VA patient, VA Secretary David Shulkin is demanding strong VA accountability measures.

"VA has been working with Congress to ensure legislation would provide VA the ability to expedite removals while still preserving an employee's right to due process. Without these legislative changes, VA will continue to be forced to delay immediate actions to remove employees from federal service," the VA wrote in a statement. The VA Secretary is referring to the VA Accountability First Act of 2017, a measure that would shorten the termination and appeals process for removing bad employees while protecting whistleblowers who speak up about wrongdoings.

Concerned Veterans for America (CVA) Policy Director Dan Caldwell issued the following statement:

> "It is incredibly refreshing to see Dr. Shulkin emphatically calling for strong accountability measures at the VA. Under the previous administration, the Secretaries spent most of their time denying that problems within the department existed. By acknowledging the need for systemic reform, Secretary Shulkin has taken a bold and courageous step in helping veterans push Congress to pass meaningful accountability legislation.
>
> "An employee caught watching pornography with a VA patient should be escorted out of the building immediately, never to return. The VA is forced to retain employees like this due to incredibly cumbersome and bureaucratic regulations. To change this, the Senate must move quickly on the VA Accountability First Act of 2017, a bill supported by the President, VA Secretary, major veteran organizations, and veterans around the country who need and deserve better care than what they're getting from the VA."

CVA supports the VA Accountability First Act of 2017, which passed through the House with bipartisan support earlier this month. The Senate version of the bill, introduced by Senator Marco Rubio (R-FL), has not yet been scheduled for a vote.

If passed, the 2017 VA Accountability First Act would drastically shorten the overall termination and appeals process

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for Department of Veterans Affairs (VA) employees who are found to have engaged in misconduct. Currently, that process can take months or even years. The bill also empowers the VA Secretary to recoup bonuses awarded in error or given to employees who were later found to have engaged in misconduct. Additionally, the bill gives the VA Secretary the ability to reduce the pensions of VA employees who are convicted of felonies that influenced their job performance.

Earlier this week, it was reported that one VA hospital held a job open for its accountant while he served a prison term for killing someone and hired a convicted child molester, keeping him on VA payroll while he repeatedly reoffended.

###

If you would rather not receive future communications from Concerned Veterans for America, please go to https://optout.cision.com/en/2L1qdTrCUnjiC2jNY1bavkvLLsduCrVLSqatgFsbFtqqHnuD2i86vPbmc7itPAXk5bAdJu3mdaBt8dckgr5uUi38Kh8cYRBWyhYbBHxWNZEQ6CXY6EmzF9NQvsnV3NcjWkfc.
Concerned Veterans for America, 1310 N. Courthouse Rd, Arlington, 22201 VA, USA

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> To: (b) (6) [redacted]@gmail.com
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> **Media Contact:** press@cv4a.org
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VA, USA

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Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/1/2017 7:31:30 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: CVA Support of your statement today

Great, happy to assist.

On Sat, Apr 1, 2017 at 12:22 PM, David shulkin <Drshulkin@aol.com> wrote:
I like this idea

Up until now I wasnt sure who could do this but i agree

Sent from my iPhone

On Apr 1, 2017, at 3:15 PM, Darin Selnick <(b) (6) @gmail.com> wrote:

> Just a thought, as part of being proactive with the press we could have both an internal and external surrogate program in order to drive our VA narrative.
>
> That is what we did at VA and why CVA is in the media so much.
>
> Internally we can have besides you, a few trusted senior staff to meet with the media, they can be trained. Externally we can people like Newt Gingrich. We all would have talking points so we drive our message.
>
> For example on this story, I could have gone on Fox and Friends as your surrogate. I did this all the time at CVA and was on a number of Fox shows and CNN. I can do again if you want in the future.
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> Something to explore with your new Asst Sec OPIA and WH.
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AMERICAN OVERSIGHT

Darin

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From: **CVA - Press** <press@cv4a.org>
Date: Fri, Mar 31, 2017 at 5:35 PM
Subject: Unable to Quickly Fire Porn-Watching Employee, VA Secretary Demands Accountability Legislation Is Taken Up
To: (b) (6) [redacted]@gmail.com

For Immediate Release: March 31, 2017
Media Contact: press@cv4a.org

CONCERNED VETERANS FOR AMERICA

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Concerned Veterans for America, 1310 N. Courthouse Rd, Arlington, 22201 VA, USA

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> > From: **CVA - Press** <press@cv4a.org>

AMERICAN OVERSIGHT

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Concerned Veterans for America, 1310 N. Courthouse Rd, Arlington, 22201 VA, USA

AMERICAN OVERSIGHT

Message

From: Wright, Vivieca (Simpson) [Vivieca.Wright@va.gov]
Sent: 4/1/2017 3:00:10 PM
To: 'David shulkin' [Drshulkin@aol.com]
Subject: RE: [EXTERNAL] Fwd: CVA Support of your statement today

Great!

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From: David shulkin [Drshulkin@aol.com]
Sent: Saturday, April 01, 2017 10:58 AM Eastern Standard Time
To: Wright, Vivieca (Simpson)
Subject: Re: [EXTERNAL] Fwd: CVA Support of your statement today

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Sent from my iPhone

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> **From:** David shulkin [Drshulkin@aol.com]
> **Sent:** Saturday, April 01, 2017 08:09 AM Eastern Standard Time
> **To:** Wright, Vivieca (Simpson)
> **Subject:** [EXTERNAL] Fwd: CVA Support of your statement today
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> Begin forwarded message:
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> > **From:** Darin Selnick <(b) (6) [redacted]@gmail.com>
> > **Date:** March 31, 2017 at 10:50:15 PM EDT
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AMERICAN OVERSIGHT

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Date: Fri, Mar 31, 2017 at 5:35 PM
Subject: Unable to Quickly Fire Porn-Watching Employee, VA Secretary Demands Accountability Legislation Is Taken Up
To: (b) (6) k@gmail.com

For Immediate Release: March 31, 2017
Media Contact: press@cv4a.org

CONCERNED VETERANS FOR AMERICA

Unable to Quickly Fire Porn-Watching Employee, VA Secretary Demands Accountability Legislation Is Taken Up

AMERICAN OVERSIGHT

Arlington, VA – After the Department of Veterans Affairs (VA) failed to quickly remove an employee caught watching pornography with a VA patient, VA Secretary David Shulkin is demanding strong VA accountability measures.

"VA has been working with Congress to ensure legislation would provide VA the ability to expedite removals while still preserving an employee's right to due process. Without these legislative changes, VA will continue to be forced to delay immediate actions to remove employees from federal service," the VA wrote in a statement. The VA Secretary is referring to the VA Accountability First Act of 2017, a measure that would shorten the termination and appeals process for removing bad employees while protecting whistleblowers who speak up about wrongdoings.

Concerned Veterans for America (CVA) Policy Director Dan Caldwell issued the following statement:

> "It is incredibly refreshing to see Dr. Shulkin emphatically calling for strong accountability measures at the VA. Under the previous administration, the Secretaries spent most of their time denying that problems within the department existed. By acknowledging the need for systemic reform, Secretary Shulkin has taken a bold and courageous step in helping veterans push Congress to pass meaningful accountability legislation.
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> "An employee caught watching pornography with a VA patient should be escorted out of the building immediately, never to return. The VA is forced to retain employees like this due to incredibly cumbersome and bureaucratic regulations. To change this, the Senate must move quickly on the VA Accountability First Act of 2017, a bill supported by the President, VA Secretary, major veteran organizations, and veterans around the country who need and deserve better care than what they're getting from the VA."

CVA supports the VA Accountability First Act of 2017, which passed through the House with bipartisan support earlier this month. The Senate version of the bill, introduced by Senator Marco Rubio (R-FL), has not yet been scheduled for a vote.

If passed, the 2017 VA Accountability First Act would drastically shorten the overall termination and appeals process for Department of Veterans Affairs (VA) employees who are found to have engaged in misconduct. Currently, that process can take months or even years. The bill also empowers the VA Secretary to recoup bonuses awarded in error or given to employees who were later found to have engaged in misconduct. Additionally, the bill gives the VA Secretary the ability to reduce the pensions of VA employees who are convicted of felonies that influenced their job performance.

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###

If you would rather not receive future communications from Concerned Veterans for America,

AMERICAN OVERSIGHT

please go to
https://optout.cision.com/en/2L1qdTrCUnjiC2jNY1bavkvLLsduCrVLSqatgFsbFtqqHnuD2i86vPbmc7itPAXk5bAdJu3mdaBt8dckgr5uUi38Kh8cYRBWyhYbBHxWNZEQ6CXY6EmzF9NQvsnV3NcjWkfc.
Concerned Veterans for America, 1310 N. Courthouse Rd, Arlington, 22201 VA, USA

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/1/2017 12:08:56 PM
To: Darin Selnick [(b) (6) [redacted]@gmail.com]
Subject: Re: CVA Support of your statement today

This is really great to see

Please thank them on behalf of all of us at the Department

Sent from my iPhone

On Mar 31, 2017, at 10:50 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:

> FYI
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> I thought you would want to see the CVA statement supporting you. Starting Monday they will be pushing on Senate members to move the bill.
>
> Darin
>
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> **Media Contact:** press@cv4a.org
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AMERICAN OVERSIGHT

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https://optout.cision.com/en/2L1qdTrCUnjiC2jNY1bavkvLLsduCrVLSqatgFsbFtqqHnuD2i86v

AMERICAN OVERSIGHT

Pbmc7itPAXk5bAdJu3mdaBt8dckgr5uUi38Kh8cYRBWyhYbBHxWNZEQ6CXY6EmzF9NQvsnV3NcjWkfc.
Concerned Veterans for America, 1310 N. Courthouse Rd, Arlington, 22201 VA, USA

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) [redacted]@gmail.com]
Sent: 4/1/2017 2:50:15 AM
To: David shulkin [Drshulkin@aol.com]
Subject: CVA Support of your statement today

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AMERICAN OVERSIGHT

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Concerned Veterans for America, 1310 N. Courthouse Rd, Arlington, 22201 VA, USA

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 4:29:13 PM
To: (b) (6) [(b) (6) pcommgroup.com]
CC: IP [(b) (6) frenchangel59.com]; Marisol Garcia [(b) (6) frenchangel59.com]; (b) (6) [(b) (6) pcommgroup.com]; Vivieca Simpson [(b) (6) gmail.com]
Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

I like the way you think

Sent from my iPhone

On Apr 3, 2017, at 12:02 PM, (b) (6) <(b) (6) pcommgroup.com> wrote:

> Thank you. Understood. We can also call it a volunteer communications advisory committee etc.
>
> On Apr 3, 2017, at 9:00 AM, David shulkin <Drshulkin@aol.com> wrote:
>
> > (b) (6) thanks so much . Like many things in government- its always a bit complicated. There are rules around task forces so let me get some internal guidance on the least complex way to approach this.
> >
> > Thanks
> >
> > David Shulkin
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> > Sent from my iPhone
> >
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> > > As per below the only target I socialized the idea with was (b) (6) who heads communications for 21st Century Fox and the Murdochs.
> > >
> > > I think the approach is critical, from my POV it is important we outline the task force's specific goals, time commitment and if applicable the corporate approval/support/relationship that exists (i.e. Apple, Johnson & Johnson, Disney, Fox, etc).
> > >
> > > To this end, I suggest the following:
> > > 1) <!--[if !supportLists]--><!--[endif]-->We will draft an outline of the Task Force's role, commitment and goals.
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AMERICAN OVERSIGHT

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- <!--[if !supportLists]--><!--[endif]-->Where there is no existing C-Suite relationship, we can navigate the best route to reach each target, in many or most cases we can provide.

I assume all costs associated with travel and accommodations would be subsidized by the host company.

Available to speak as needed.
Best,
[redacted]

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Monday, April 3, 2017 3:59 AM
To: [redacted] <[redacted]pcommgroup.com>
Cc: IP <[redacted]frenchangel59.com>; Marisol Garcia <[redacted]frenchangel59.com>; [redacted] <[redacted]pcommgroup.com>
Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

[redacted] once again thank you. This is a perfect list and you did an amazing job pulling it together.

As a next step - is this a group of prospects or is this a group that has already agreed to help?

Should i reach out to them to invite them to join an advisory group? Or do you have a different suggestion?

David Shulkin
Secretary, US Department of Veterans Affairs

Sent from my iPhone

On Mar 28, 2017, at 3:41 PM, [redacted] <[redacted]pcommgroup.com> wrote:

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> Please note, the only name we approached was [redacted] of 21st Century Fox, who is committed to the idea and involvement and shared that her

AMERICAN OVERSIGHT

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We look forward to discussing next steps and defer to Ike on positioning and final thoughts.

Best,
(b) (6) & Paul

<VA Comms Committee Draft 1 3.28.17.docx>

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]pcommgroup.com]
Sent: 4/3/2017 4:02:27 PM
To: David shulkin [Drshulkin@aol.com]
CC: IP [redacted]frenchangel59.com]; Marisol Garcia [redacted]frenchangel59.com]; [redacted] [redacted]pcommgroup.com]; Vivieca Simpson [redacted]gmail.com]
Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

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> >
> > Available to speak as needed.
> > Best,

AMERICAN OVERSIGHT

Melissa

From: David shulkin [mailto:Drshulkin@aol.com]
Sent: Monday, April 3, 2017 3:59 AM
To: [redacted] <[redacted]pcommgroup.com>
Cc: IP <[redacted]frenchangel59.com>; Marisol Garcia <[redacted]frenchangel59.com>; [redacted] <[redacted]pcommgroup.com>
Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

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> <VA Comms Committee Draft 1 3.28.17.docx>

AMERICAN OVERSIGHT

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Sent: 4/3/2017 4:00:56 PM
To: [redacted] [redacted]pcommgroup.com]
CC: IP [redacted]frenchangel59.com]; Marisol Garcia [redacted]frenchangel59.com]; [redacted] [redacted]pcommgroup.com]; Vivieca Simpson [redacted]gmail.com]
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Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

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> <VA Comms Committee Draft 1 3.28.17.docx>

AMERICAN OVERSIGHT

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From: [redacted] [redacted]pcommgroup.com]
Sent: 4/3/2017 3:21:01 PM
To: David shulkin [Drshulkin@aol.com]
CC: IP [redacted]frenchangel59.com]; Marisol Garcia [redacted]frenchangel59.com]; [redacted] [redacted]pcommgroup.com]
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CC: IP [redacted]frenchangel59.com]; Marisol Garcia [redacted]frenchangel59.com]; [redacted] [redacted]pcommgroup.com]
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> <VA Comms Committee Draft 1 3.28.17.docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 1:47:23 AM
To: Vivieca Simpson [(b) (6) gmail.com]
Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

Tommorow- im on a train from 7 am to 9 am and free again 1130- 12 est

Sent from my iPhone

On Apr 2, 2017, at 9:12 PM, Vivieca Simpson <(b) (6) gmail.com> wrote:

> Do you want to talk tonight or tomorrow.
>
> On Mar 30, 2017 12:19, "David shulkin" <Drshulkin@aol.com> wrote:
> We need to discuss somewhat urgently
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** David shulkin <Drshulkin@aol.com>
> > **Date:** March 28, 2017 at 3:13:49 PM CDT
> > **To:** Vivieca Wright Simpson <vivieca.Wright@va.gov>
> > **Subject: Fwd: DRAFT: VA COMMUNICATIONS TASK FORCE**
> >
> > Lets discuss
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > > **From:** (b) (6) <(b) (6) pcommgroup.com>
> > > **Date:** March 28, 2017 at 3:41:44 PM EDT
> > > **To:** David shulkin <Drshulkin@aol.com>, IP <ip@frenchangel59.com>
> > > **Cc:** Marisol Garcia <(b) (6) frenchangel59.com>, (b) (6) <(b) (6) pcommgroup.com>
> > > **Subject: DRAFT: VA COMMUNICATIONS TASK FORCE**
> > >
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> > >
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Please note, the only name we approached was (b) (6) of 21st Century Fox, who is committed to the idea and involvement and shared that her leadership team (the Murdoch(s)) consider the VA a priority focus.

We look forward to discussing next steps and defer to Ike on positioning and final thoughts.

Best,

(b) (6) & Paul

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Message

From: Vivieca Simpson [(b) (6) gmail.com]
Sent: 4/3/2017 1:12:06 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Fwd: DRAFT: VA COMMUNICATIONS TASK FORCE

Do you want to talk tonight or tomorrow.

On Mar 30, 2017 12:19, "David shulkin" <Drshulkin@aol.com> wrote:
We need to discuss somewhat urgently

Sent from my iPhone

Begin forwarded message:

> **From:** David shulkin <Drshulkin@aol.com>
> **Date:** March 28, 2017 at 3:13:49 PM CDT
> **To:** Vivieca Wright Simpson <vivieca.Wright@va.gov>
> **Subject: Fwd: DRAFT: VA COMMUNICATIONS TASK FORCE**
>
> Lets discuss
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** (b) (6) <(b) (6) pcommgroup.com>
> > **Date:** March 28, 2017 at 3:41:44 PM EDT
> > **To:** David shulkin <Drshulkin@aol.com>, IP <(b) (6) frenchangel59.com>
> > **Cc:** Marisol Garcia <(b) (6) frenchangel59.com>, (b) (6)
> > <(b) (6) pcommgroup.com>
> > **Subject: DRAFT: VA COMMUNICATIONS TASK FORCE**
> >
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/30/2017 5:19:45 PM
To: Vivieca Simpson [(b) (6) gmail.com]
CC: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: DRAFT: VA COMMUNICATIONS TASK FORCE
Attachments: VA Comms Committee Draft 1 3.28.17.docx; Untitled attachment 06181.htm

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VETERANS AFFAIRS: DRAFT COMMUNICATIONS COMMITTEE TARGETS
PRESENTED BY: [redacted] OF PRINCIPAL COMMUNICATIONS GROUP
DATE: 3/28/17

[redacted] - Facebook, Inc.

Vice President- Communications and Public Policy at Facebook

Mr. [redacted] serves as Vice President of Global Communications, Marketing and Public Policy at Facebook, Inc. At Facebook, Mr. [redacted] is responsible for developing and coordinating key messages about products, corporate business and partnerships. He also oversees Facebook's public policy strategy worldwide. He served as Strategic Advisor of Luminate, Inc. He served as Vice President of Public Affairs and Global Communications at Google Inc. since October 2005. He served as a Board Observer of Luminate, Inc. He helped broaden and coordinate Google's messaging from a focus on product PR to include all aspects of corporate, financial, policy, philanthropic and internal communications. Prior to Google, he was the Bernard L. Schwarz Senior Fellow in business and foreign policy at the New York-based Council on Foreign Relations. In his career, he served as Senior Vice President of Global Affairs at Gap Inc. and an Adjunct Professor at Columbia University and Columbia Law School. He is a contributor to the Harvard Business Review and the Financial Times. Mr. [redacted] holds a bachelor's degree from Harvard University, a master's degree in public policy from the Kennedy School of Government and a J.D. from Harvard Law School. He studied at Ecole Normale Superieure.

[redacted] - NFL

Executive vice president of communications

[redacted] a former press secretary for President Bill Clinton, will join the NFL as the league's executive vice president of communications. [redacted] joins the NFL from a Washington, D.C.-based communications and government affairs firm he co-founded. He was Clinton's press secretary from 1998 to 2000 and an advisor and press secretary to several presidential campaigns over two decades. Reports to NFL chief operating officer Tod Leiweke

[redacted] Apple

Vice president of Communications

[redacted] is Apple's vice president of Communications, reporting to CEO [redacted] [redacted] is responsible for Apple's worldwide media relations and communications strategy, leading the public relations team as well as employee communications and corporate events. He previously led Apple's corporate public relations team for ten years. Before joining Apple in 2003, [redacted] worked as a broadcast journalist at CNBC, first as a writer and producer in the network's Washington, D.C. bureau. He later established CNBC's Silicon Valley bureau and served as bureau chief. A native of Massachusetts, [redacted] holds a bachelor's degree in Political Science from the University of Minnesota

[redacted] - WME

Chief Communications Officer

[redacted] is chief communications officer for WME and IMG. In his position, [redacted] serves as the companies' chief communications strategist, handling media relations, internal communication, advertising, and events for all of WME's divisions and offices. [redacted] also serves as an advisor to many of the agency's clients, providing communication and marketing services to some of the world's leading artists and brands, including Hasbro, Mark Wahlberg, M. Night Shyamalan, Usher and James Frey. As a specialist in entertainment trade and business press, [redacted] has secured corporate and client profiles in such publications as the New York Times,

AMERICAN OVERSIGHT

Wall Street Journal, Los Angeles Times, Fast Company, Forbes, Financial Times, Fortune, Vanity Fair, The Hollywood Reporter and Variety. (b) (6) also oversees WME's philanthropic initiatives, including the launch of an annual all-company volunteer day and the adoption of Foster Elementary School in Compton, California. WME is helping transform the school's campus, resources and overall academic performance. Named to The Hollywood Reporter's "Next Generation" list, which recognizes the top entertainment executives under 35, (b) (6) was previously the head of Corporate Communications for the William Morris Agency. At WMA, he handled all corporate press for the agency, including coverage of its 2009 merger with Endeavor which resulted in the creation of WME. Prior to joining the William Morris Agency in 2004, (b) (6) worked in international publicity and marketing at Warner Bros. Pictures, helping to launch campaigns for such films as "Harry Potter," "Matrix Reloaded," "Ocean's Eleven" and "Mystic River." (b) (6) graduated from Boston University with a Bachelor's Degree in International Relations.

(b) (6) - AT&T

Senior Vice President, Corporate Communications

(b) (6) senior vice president of corporate communication, oversees reputation management, media relations, executive communications, financial communications, digital and social media and employee communications for AT&T Inc. He has worked more than 30 years in corporate communications, most of it in the telecommunications industry. (b) (6) provided strategic media relations and crisis communications counsel to Fortune 100 clients while working as senior vice president and senior partner at FleishmanHillard from 1996 to 2007. Before that, he spent five years leading media relations, marketing and advertising for the Oklahoma Bankers Association. He holds a bachelor's degree in journalism and public relations from Oklahoma State University

(b) (6) - McDonalds Restaurants Ltd.

Senior Vice President, Chief Marketing Officer

In January 2014 (b) (6) was promoted to Senior Vice President, Chief Marketing Officer, with responsibility for McDonald's UK, Ireland, Norway, Denmark, Sweden and Finland. (b) (6) also holds responsibility for the UK's Business Strategy & Insight function. (b) (6) joined McDonald's in 2007 and was promoted to Vice President, Marketing in September 2010 with responsibility for Marketing and Food Development. Since joining the Company, he has led his team and agency partners in the development of some of the highest performing campaigns in McDonald's UK history, including its award-winning consumer trust and 'Favourites' advertising campaigns. (b) (6) has a strong pedigree in retail having started his career in Store Management for both Marks & Spencer and Debenhams. At Marks & Spencer (b) (6) went on to cover a variety of roles culminating in the position of Corporate Marketing Planning Manager. He then moved to Blockbuster where he took up the role of Marketing Director before starting up and establishing Blockbuster Online, as Managing Director.

(b) (6) - Nike, Inc.

Chief Communications Officer

(b) (6) was named Chief Communications Officer in June 2013. (b) (6) joined Nike in 1999 as communications director for the company's EMEA region. He was named head of US communications in 2002, global brand communications director in September 2004, and vice president of global communications in November 2005.

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[redacted] - Johnson & Johnson

Worldwide Vice President, Global Corporate Affairs & Chief Communication Officer

[redacted] is Worldwide Vice President, Global Corporate Affairs & Chief Communication Officer and a member of the Corporation's Management Committee. In his role he leads the Corporation's global marketing, communication, equity and philanthropy functions. He assumed his position in January 2012. Previous to this role, Mr. [redacted] was a Company Group Chairman for Johnson & Johnson and a member of the Medical Devices & Diagnostics Group Operating Committee, a role he assumed in January 2007. He had primary responsibility for the global vision care franchise. [redacted] joined Johnson & Johnson in 1983 as a Marketing Assistant for Personal Products Company. He held positions of increasing responsibility in the marketing organization. In 1991 Mr. [redacted] moved to McNeil Consumer Products as a Group Product Director and was promoted to Vice President, Worldwide Consumer Pharmaceuticals in 1995 to lead the company's growth in the Asia Pacific, Eastern European and Latin American regions. In 1998 [redacted] relocated to Europe as Managing Director, McNeil Consumer Nutritionals Europe. He returned to the U.S. as President, McNeil Nutritionals Worldwide, in 2000. In 2002 he was named Global President, Personal Products Company. [redacted] was promoted to Company Group Chairman and a member of the Consumer and Personal Care Group Operating Committee in 2004, with North American responsibility for the Personal Products Company, Johnson & Johnson Sales and Logistics Company and Johnson & Johnson Consumer Canada. In his role he also had North American responsibility for the IT, Finance and HR organizations within the Consumer & Personal Care group. [redacted] is a member of the board of trustees at Macalester College and a member of the Executive Committee of the Board of Directors of Family Service Association. He also serves on the Executive Committee of the Ad Council. He holds a Master's degree in business administration from the Tuck School of Business at Dartmouth College and a Bachelor of Arts' degree, cum laude, from Macalester College.

[redacted] - American Express Company

Executive Vice President, Corporate Affairs & Communications

[redacted] is Executive Vice President, Corporate Affairs & Communications, American Express Company. He is a member of the Company's Operating Committee, with responsibility for Public and Shareholder Communications, International Government Affairs, Corporate Social Responsibility and Public Policy. Mr. [redacted] joined American Express in 1991 from Shearson Lehman Brothers Inc., where he had been Senior Vice President, Corporate Affairs and Communications. Prior to joining the securities industry in 1987, Mr. [redacted] worked for Manufacturers Hanover Trust Company in New York. Mr. [redacted] is a director and former Chairman of the Public Relations Seminar. He has also served as Chairman of The Wisemen, an organization of senior public relations executives founded in New York in 1938. Mr. [redacted] is a former director of Kids in a Drug Free Society and a 2005 David Rockefeller Fellow. A graduate of the State University of New York at Buffalo, Mr. [redacted] is married and resides in New York City.

[redacted] - 21st Century Fox

Executive Vice President and Chief Communications Officer for 21st Century Fox

[redacted] is the Executive Vice President and Chief Communications Officer for 21st Century Fox. In this role, Ms. [redacted] serves as the chief spokesperson for the Company, leading all global communications initiatives, specifically in support of corporate financial matters, mergers and acquisitions, regulatory issues and

AMERICAN OVERSIGHT

litigation. She is also responsible for leading the Company's efforts to build and manage the 21st Century Fox corporate brand among key audiences worldwide. She has served as Chief Communications Officer since January 2012. Prior to her current post, Ms. [redacted] was the Company's Senior Vice President of Communications and Corporate Strategy. In addition to her communications responsibilities, she was called upon to develop company-wide marketing and distribution strategies designed to drive greater value from the Company's deep portfolio of media and publishing assets. Previously, Ms. [redacted] served as the Company's Senior Vice President Corporate Communications and Public Affairs, focusing on its West Coast businesses. She first joined the Company as Senior Vice President of Corporate Communications for Fox Interactive Media (FIM) and MySpace. Before joining the Company, Ms. [redacted] was a Senior Vice President at MPRM Public Relations from 1994 to 2006. At MPRM, she ran the digital practice, working with companies at the intersection of media and technology. Ms. [redacted] resides in Los Angeles with her husband and two children.

[redacted] – Walt Disney Company
Executive Vice President and Chief Communications Officer

[redacted] is responsible for global communications for The Walt Disney Company, including acting as chief spokesperson and overseeing communication strategy and media relations for the company, its various business segments and its philanthropic and environmental initiatives. Her role also includes oversight of internal communications, the Walt Disney Archives and D23.
Since 2002, Ms. [redacted] has led the communications and positioning strategy for all of Disney's strategic business initiatives including the acquisitions of Pixar, Marvel and Lucasfilm; the Company's leadership in leveraging digital technology to connect consumers to creative content in new and exciting ways; and its expansion and growth in international such as the landmark opening of Disney's first theme park and resort in Mainland China, Shanghai Disney Resort.
Under her direction, Disney launched D23, the first-ever official Disney fan club, with members in all 50 states and 35 countries. Since its 2009 debut, D23 has delighted Disney fans with experiences such as the bi-annual D23 Expo: The Ultimate Disney Fan Event, year-round member-only insider access events, and the award-winning quarterly magazine, Disney Twenty-three.
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Ms. [redacted] previously served as communications director for United States Senator Alfonse D'Amato, managing his successful re-election campaigns in 1986 and 1992. She originally joined Senator D'Amato's team in 1982 as a press representative.
In 2012 Ms. [redacted] received the prestigious Matrix Award from New York Women in Communications, Inc. She has also been named one of the 100 Most Important In-House Communicators in the World by The Holmes Report, PR Week's Top 50 Industry Elite and was recognized on PR Week's Power List for 2014.

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DS_00003073

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/29/2017 12:45:36 AM
To: (b) (6) va.gov
Subject: Fwd: DRAFT: VA COMMUNICATIONS TASK FORCE
Attachments: VA Comms Committee Draft 1 3.28.17.docx; Untitled attachment 06186.htm

Please print

Sent from my iPhone

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VA-19-0799-D-001408
DS_00003079

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From: David shulkin [Drshulkin@aol.com]
Sent: 3/28/2017 8:14:16 PM
To: (b) (6) [(b) (6) pcommgroup.com]
CC: IP [(b) (6) frenchangel59.com]; Marisol Garcia [(b) (6) frenchangel59.com]; (b) (6) [(b) (6) pcommgroup.com]
Subject: Re: DRAFT: VA COMMUNICATIONS TASK FORCE

Thanks so much (b) (6) and Paul

Ill be in touch soon

Sent from my iPhone

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> We look forward to discussing next steps and defer to Ike on positioning and final thoughts.
>
> Best,
> (b) (6) & Paul
>
> <VA Comms Committee Draft 1 3.28.17.docx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/28/2017 8:13:49 PM
To: Vivieca Wright Simpson [vivieca.Wright@va.gov]
Subject: Fwd: DRAFT: VA COMMUNICATIONS TASK FORCE
Attachments: VA Comms Committee Draft 1 3.28.17.docx; Untitled attachment 06193.htm

Lets discuss

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) pcommgroup.com>
Date: March 28, 2017 at 3:41:44 PM EDT
To: David shulkin <Drshulkin@aol.com>, IP <(b) (6) frenchangel59.com>
Cc: Marisol Garcia <(b) (6) frenchangel59.com>, (b) (6) <(b) (6) pcommgroup.com>
Subject: DRAFT: VA COMMUNICATIONS TASK FORCE

Dr. Shulkin:
It was a privilege to speak last week. Per our conversation, please see a DRAFT list of proposed names to target for the Communications Committee- whose responsibility it will be to identify near term and intermediate VA Communications goals, specific near term opportunities and evaluate, and if necessary staff and resource.

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VETERANS AFFAIRS: DRAFT COMMUNICATIONS COMMITTEE TARGETS
PRESENTED BY: [redacted] OF PRINCIPAL COMMUNICATIONS GROUP
DATE: 3/28/17

[redacted] - Facebook, Inc.

Vice President- Communications and Public Policy at Facebook

Mr. [redacted] serves as Vice President of Global Communications, Marketing and Public Policy at Facebook, Inc. At Facebook, Mr. [redacted] is responsible for developing and coordinating key messages about products, corporate business and partnerships. He also oversees Facebook's public policy strategy worldwide. He served as Strategic Advisor of Luminate, Inc. He served as Vice President of Public Affairs and Global Communications at Google Inc. since October 2005. He served as a Board Observer of Luminate, Inc. He helped broaden and coordinate Google's messaging from a focus on product PR to include all aspects of corporate, financial, policy, philanthropic and internal communications. Prior to Google, he was the Bernard L. Schwarz Senior Fellow in business and foreign policy at the New York-based Council on Foreign Relations. In his career, he served as Senior Vice President of Global Affairs at Gap Inc. and an Adjunct Professor at Columbia University and Columbia Law School. He is a contributor to the Harvard Business Review and the Financial Times. Mr. [redacted] holds a bachelor's degree from Harvard University, a master's degree in public policy from the Kennedy School of Government and a J.D. from Harvard Law School. He studied at Ecole Normale Superieure.

[redacted] - NFL

Executive vice president of communications

[redacted] a former press secretary for President Bill Clinton, will join the NFL as the league's executive vice president of communications. [redacted] joins the NFL from a Washington, D.C.-based communications and government affairs firm he co-founded. He was Clinton's press secretary from 1998 to 2000 and an advisor and press secretary to several presidential campaigns over two decades. Reports to NFL chief operating officer Tod Leiweke

[redacted] Apple

Vice president of Communications

[redacted] is Apple's vice president of Communications, reporting to CEO [redacted] [redacted] is responsible for Apple's worldwide media relations and communications strategy, leading the public relations team as well as employee communications and corporate events. He previously led Apple's corporate public relations team for ten years. Before joining Apple in 2003, [redacted] worked as a broadcast journalist at CNBC, first as a writer and producer in the network's Washington, D.C. bureau. He later established CNBC's Silicon Valley bureau and served as bureau chief. A native of Massachusetts, [redacted] holds a bachelor's degree in Political Science from the University of Minnesota

[redacted] - WME

Chief Communications Officer

[redacted] is chief communications officer for WME and IMG. In his position, [redacted] serves as the companies' chief communications strategist, handling media relations, internal communication, advertising, and events for all of WME's divisions and offices. [redacted] also serves as an advisor to many of the agency's clients, providing communication and marketing services to some of the world's leading artists and brands, including Hasbro, [redacted] Wahlberg, M. Night Shyamalan, Usher and James Frey. As a specialist in entertainment trade and business press, [redacted] has secured corporate and client profiles in such publications as the New York Times,

AMERICAN OVERSIGHT

Wall Street Journal, Los Angeles Times, Fast Company, Forbes, Financial Times, Fortune, Vanity Fair, The Hollywood Reporter and Variety. (b) (6) also oversees WME's philanthropic initiatives, including the launch of an annual all-company volunteer day and the adoption of Foster Elementary School in Compton, California. WME is helping transform the school's campus, resources and overall academic performance. Named to The Hollywood Reporter's "Next Generation" list, which recognizes the top entertainment executives under 35, (b) (6) was previously the head of Corporate Communications for the William Morris Agency. At WMA, he handled all corporate press for the agency, including coverage of its 2009 merger with Endeavor which resulted in the creation of WME. Prior to joining the William Morris Agency in 2004, (b) (6) worked in international publicity and marketing at Warner Bros. Pictures, helping to launch campaigns for such films as "Harry Potter," "Matrix Reloaded," "Ocean's Eleven" and "Mystic River." (b) (6) graduated from Boston University with a Bachelor's Degree in International Relations.

(b) (6) - AT&T

Senior Vice President, Corporate Communications

(b) (6) senior vice president of corporate communication, oversees reputation management, media relations, executive communications, financial communications, digital and social media and employee communications for AT&T Inc. He has worked more than 30 years in corporate communications, most of it in the telecommunications industry. (b) (6) provided strategic media relations and crisis communications counsel to Fortune 100 clients while working as senior vice president and senior partner at FleishmanHillard from 1996 to 2007. Before that, he spent five years leading media relations, marketing and advertising for the Oklahoma Bankers Association. He holds a bachelor's degree in journalism and public relations from Oklahoma State University

(b) (6) - McDonalds Restaurants Ltd.

Senior Vice President, Chief Marketing Officer

In January 2014 (b) (6) was promoted to Senior Vice President, Chief Marketing Officer, with responsibility for McDonald's UK, Ireland, Norway, Denmark, Sweden and Finland. (b) (6) also holds responsibility for the UK's Business Strategy & Insight function. (b) (6) joined McDonald's in 2007 and was promoted to Vice President, Marketing in September 2010 with responsibility for Marketing and Food Development. Since joining the Company, he has led his team and agency partners in the development of some of the highest performing campaigns in McDonald's UK history, including its award-winning consumer trust and 'Favourites' advertising campaigns. (b) (6) has a strong pedigree in retail having started his career in Store Management for both Marks & (b) (6) and Debenhams. At Marks & (b) (6) (b) (6) went on to cover a variety of roles culminating in the position of Corporate Marketing Planning Manager. He then moved to Blockbuster where he took up the role of Marketing Director before starting up and establishing Blockbuster Online, as Managing Director.

(b) (6) - Nike, Inc.

Chief Communications Officer

(b) (6) was named Chief Communications Officer in June 2013. (b) (6) joined Nike in 1999 as communications director for the company's EMEA region. He was named head of US communications in 2002, global brand communications director in September 2004, and vice president of global communications in November 2005.

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[redacted] - Johnson & Johnson

Worldwide Vice President, Global Corporate Affairs & Chief Communication Officer

[redacted] is Worldwide Vice President, Global Corporate Affairs & Chief Communication Officer and a member of the Corporation's Management Committee. In his role he leads the Corporation's global marketing, communication, equity and philanthropy functions. He assumed his position in January 2012. Previous to this role, Mr. [redacted] was a Company Group Chairman for Johnson & Johnson and a member of the Medical Devices & Diagnostics Group Operating Committee, a role he assumed in January 2007. He had primary responsibility for the global vision care franchise. [redacted] joined Johnson & Johnson in 1983 as a Marketing Assistant for Personal Products Company. He held positions of increasing responsibility in the marketing organization. In 1991 Mr. [redacted] moved to McNeil Consumer Products as a Group Product Director and was promoted to Vice President, Worldwide Consumer Pharmaceuticals in 1995 to lead the company's growth in the Asia Pacific, Eastern European and Latin American regions. In 1998 [redacted] relocated to Europe as Managing Director, McNeil Consumer Nutritionals Europe. He returned to the U.S. as President, McNeil Nutritionals Worldwide, in 2000. In 2002 he was named Global President, Personal Products Company. [redacted] was promoted to Company Group Chairman and a member of the Consumer and Personal Care Group Operating Committee in 2004, with North American responsibility for the Personal Products Company, Johnson & Johnson Sales and Logistics Company and Johnson & Johnson Consumer Canada. In his role he also had North American responsibility for the IT, Finance and HR organizations within the Consumer & Personal Care group. [redacted] is a member of the board of trustees at Macalester College and a member of the Executive Committee of the Board of Directors of Family Service Association. He also serves on the Executive Committee of the Ad Council. He holds a Master's degree in business administration from the Tuck School of Business at Dartmouth College and a Bachelor of Arts' degree, cum laude, from Macalester College.

[redacted] - American Express Company

Executive Vice President, Corporate Affairs & Communications

[redacted] is Executive Vice President, Corporate Affairs & Communications, American Express Company. He is a member of the Company's Operating Committee, with responsibility for Public and Shareholder Communications, International Government Affairs, Corporate Social Responsibility and Public Policy. Mr. [redacted] joined American Express in 1991 from Shearson Lehman Brothers Inc., where he had been Senior Vice President, Corporate Affairs and Communications. Prior to joining the securities industry in 1987, Mr. [redacted] worked for Manufacturers Hanover Trust Company in New York. Mr. [redacted] is a director and former Chairman of the Public Relations Seminar. He has also served as Chairman of The Wisemen, an organization of senior public relations executives founded in New York in 1938. Mr. [redacted] is a former director of Kids in a Drug Free Society and a 2005 David Rockefeller Fellow. A graduate of the State University of New York at Buffalo, Mr. [redacted] is married and resides in New York City.

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Executive Vice President and Chief Communications Officer for 21st Century Fox

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AMERICAN OVERSIGHT

litigation. She is also responsible for leading the Company's efforts to build and manage the 21st Century Fox corporate brand among key audiences worldwide. She has served as Chief Communications Officer since January 2012. Prior to her current post, Ms. [redacted] was the Company's Senior Vice President of Communications and Corporate Strategy. In addition to her communications responsibilities, she was called upon to develop company-wide marketing and distribution strategies designed to drive greater value from the Company's deep portfolio of media and publishing assets. Previously, Ms. [redacted] served as the Company's Senior Vice President Corporate Communications and Public Affairs, focusing on its West Coast businesses. She first joined the Company as Senior Vice President of Corporate Communications for Fox Interactive Media (FIM) and MySpace. Before joining the Company, Ms. [redacted] was a Senior Vice President at MPRM Public Relations from 1994 to 2006. At MPRM, she ran the digital practice, working with companies at the intersection of media and technology. Ms. [redacted] resides in Los Angeles with her husband and two children.

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Since 2002, Ms. [redacted] has led the communications and positioning strategy for all of Disney's strategic business initiatives including the acquisitions of Pixar, Marvel and Lucasfilm; the Company's leadership in leveraging digital technology to connect consumers to creative content in new and exciting ways; and its expansion and growth in international such as the landmark opening of Disney's first theme park and resort in Mainland China, Shanghai Disney Resort.
Under her direction, Disney launched D23, the first-ever official Disney fan club, with members in all 50 states and 35 countries. Since its 2009 debut, D23 has delighted Disney fans with experiences such as the bi-annual D23 Expo: The Ultimate Disney Fan Event, year-round member-only insider access events, and the award-winning quarterly magazine, Disney Twenty-three.
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Prior to joining The Walt Disney Company, Ms. [redacted] served as director of communications and senior policy advisor to New York State Governor George Pataki. In these roles, she counseled him on a broad range of public policy and other issues and successfully positioned him for re-election, earning a national reputation for her communication strategy and political expertise in the process. The New York Times described her role as expanded beyond communications, "to include virtually every major decision made by the Governor."
Ms. [redacted] previously served as communications director for United States Senator Alfonse D'Amato, managing his successful re-election campaigns in 1986 and 1992. She originally joined Senator D'Amato's team in 1982 as a press representative.
In 2012 Ms. [redacted] received the prestigious Matrix Award from New York Women in Communications, Inc. She has also been named one of the 100 Most Important In-House Communicators in the World by The Holmes Report, PR Week's Top 50 Industry Elite and was recognized on PR Week's Power List for 2014.

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VA-19-0799-D-001415
DS_00003086

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Message

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Sent: 3/28/2017 7:41:44 PM
To: David shulkin [Drshulkin@aol.com]; IP [redacted]frenchangel59.com]
CC: Marisol Garcia [redacted]frenchangel59.com]; [redacted] [redacted]pcommgroup.com]
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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VA-19-0799-D-001421
DS_00003092

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 10:39:22 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Take care

No finger pointing but people simply atnt listening and continuing old patterns

Sent from my iPhone

> On Mar 31, 2017, at 5:23 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> I agree that this is something you have to be involved in with me. The field is now feeling the urgency and welcome the ability for definitive action thanks to your strong messaging, but they need support in their actions at the VA level since all of this gets stalled by the legal and statutory interpretation amongst other things David, as leaders we have to stay calm and give them the support they need. This is a culture change and doesn't happen with just showing frustration. We need to also give them the tools for execution and free them of the shackles. It's a system change, even though I know how impatient we are. And that's why you have this job- remember what everyone says including POTUS- it's the hardest job in the USA. The message today is that given the current environment, how do we take the risk and bring about change in accountability. How can we make today different from the past? No finger pointing when you have the discussion today please- it will only make things difficult. Just a collaborative discussion that will result in fast and urgent sustainable change
>
> Sent from my iPhone
>
>> On Mar 31, 2017, at 2:09 AM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> The accountability stuff is out of control and killing vha
>>
>> Remember how everyone laughed when fox asked me about employees watching porn
>>
>> And we actually allow this?
>>
>> This was easy - employee should have been fired on the spot- instead we detailed them to A desk job and then pay them to do nothing
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>> Then i read that ridiculous email from skye that says because it was regular porn and not child porn we have to wait weeks
>>
>>
>>
>> By the way the shrevsport director is still our employee and has nit been fired and you should hear about how bad he is
>>
>> This is easy- really easy - and it just takes leadership to say that this stops here
>>
>> I will handle this
>>
>> Sent from my iPhone
>>
>>> On Mar 30, 2017, at 7:56 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>>
>>> Anything else brewing besides these accountability issues? Getting a little worried about things there now- and you. Take care of yourself- I will stay connected
>>>
>>> Sent from my iPhone
>>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
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To: David shulkin [Drshulkin@aol.com]
Subject: Re: Take care

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>>
>> Anything else brewing besides these accountability issues? Getting a little worried about things there now- and you. Take care of yourself- I will stay connected
>>
>> Sent from my iPhone
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 12:59:02 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Take care

The accountability stuff is out of control and killing vha

Remember how everyone laughed when fox asked me about employees watching porn

And we actually allow this?

This was easy - employee should have been fired on the spot- instead we detailed them to A desk job and then pay them to do nothing

Then i read that ridiculous email from skye that says because it was regular porn and not child porn we have to wait weeks

By the way the shrevsport director is still our employee and has nit been fired and you should hear about how bad he is

This is easy- really easy - and it just takes leadership to say that this stops here

I will handle this

Sent from my iPhone

> On Mar 30, 2017, at 7:56 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Anything else brewing besides these accountability issues? Getting a little worried about things there now- and you. Take care of yourself- I will stay connected
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/30/2017 11:56:22 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Take care

Anything else brewing besides these accountability issues? Getting a little worried about things there now- and you. Take care of yourself- I will stay connected

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 1:52:14 AM
To: (b) (6) [(b) (6) gmail.com]

Did we send (b) (6) the last eo thst was not cut off

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/29/2017 9:51:19 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David Shulkin [drshulkin@aol.com]
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Thanks that is great to hear and will be a part of our communications strategy

---

From: Bruce Moskowitz <(b) (6) mac.com>
Sent: Wednesday, March 29, 2017 5:42 AM
To: Poonam Alaigh
Cc: David Shulkin
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

All are enthusiastically standing behind this important initiative

Sent from my iPad
Bruce Moskowitz M.D.

> On Mar 28, 2017, at 10:23 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> Bruce- any feedback from the Big Five? Would want to also see if they can send out a public statement after the launch on 4/12
>
> Sent from my iPhone
>
>> On Mar 25, 2017, at 12:49 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>
>> Please see attached power point for our discussion tomorrow - thanks
>>
>>
>> _____
>> From: Bruce Moskowitz <(b) (6) mac.com>
>> Sent: Saturday, March 25, 2017 8:52 AM
>> To: Poonam Alaigh
>> Cc: David Shulkin
>> Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am
>>
>> Ok
>>
>> Sent from my iPhone
>>
>> On Mar 25, 2017, at 8:46 AM, Poonam Alaigh <(b) (6) hotmail.com<mailto:(b) (6) otmail.com>> wrote:
>>
>>
>> Bruce and David- confirming our conference call tomorrow at 11am. I will dial both of you in at that time.
>>
>>
>> David, will you please send the slides to both of all of us- if you dont have them, I will try to get them today.
>>
>> <Access and Quality Metric Screenshots.pptx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/29/2017 2:23:52 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David Shulkin [drshulkin@aol.com]
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Bruce- any feedback from the Big Five? Would want to also see if they can send out a public statement after the launch on 4/12

Sent from my iPhone

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>
> <Access and Quality Metric Screenshots.pptx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) [redacted]hotmail.com]
Sent: 3/26/2017 3:00:45 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: Publicly Facing Transparency Website- Confirming call tomorrow at 11am
Attachments: Access and Quality Metric Screenshots.pptx

From: Poonam Alaigh <(b) (6) [redacted]hotmail.com>
Sent: Saturday, March 25, 2017 12:49 PM
To: Bruce Moskowitz
Cc: David Shulkin
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Please see attached power point for our discussion tomorrow - thanks

---

From: Bruce Moskowitz <(b) (6) [redacted]mac.com>
Sent: Saturday, March 25, 2017 8:52 AM
To: Poonam Alaigh
Cc: David Shulkin
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Ok

Sent from my iPhone

On Mar 25, 2017, at 8:46 AM, Poonam Alaigh <(b) (6) [redacted]hotmail.com> wrote:

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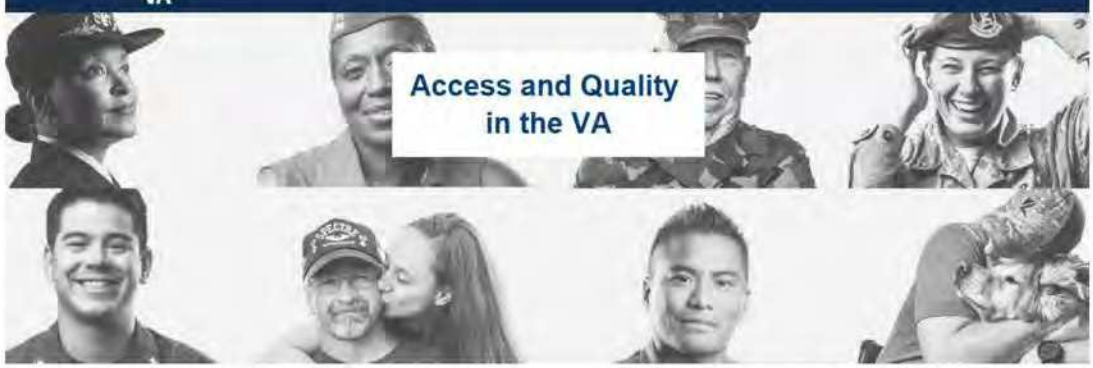
AMERICAN OVERSIGHT

VA



Access and Quality in the VA

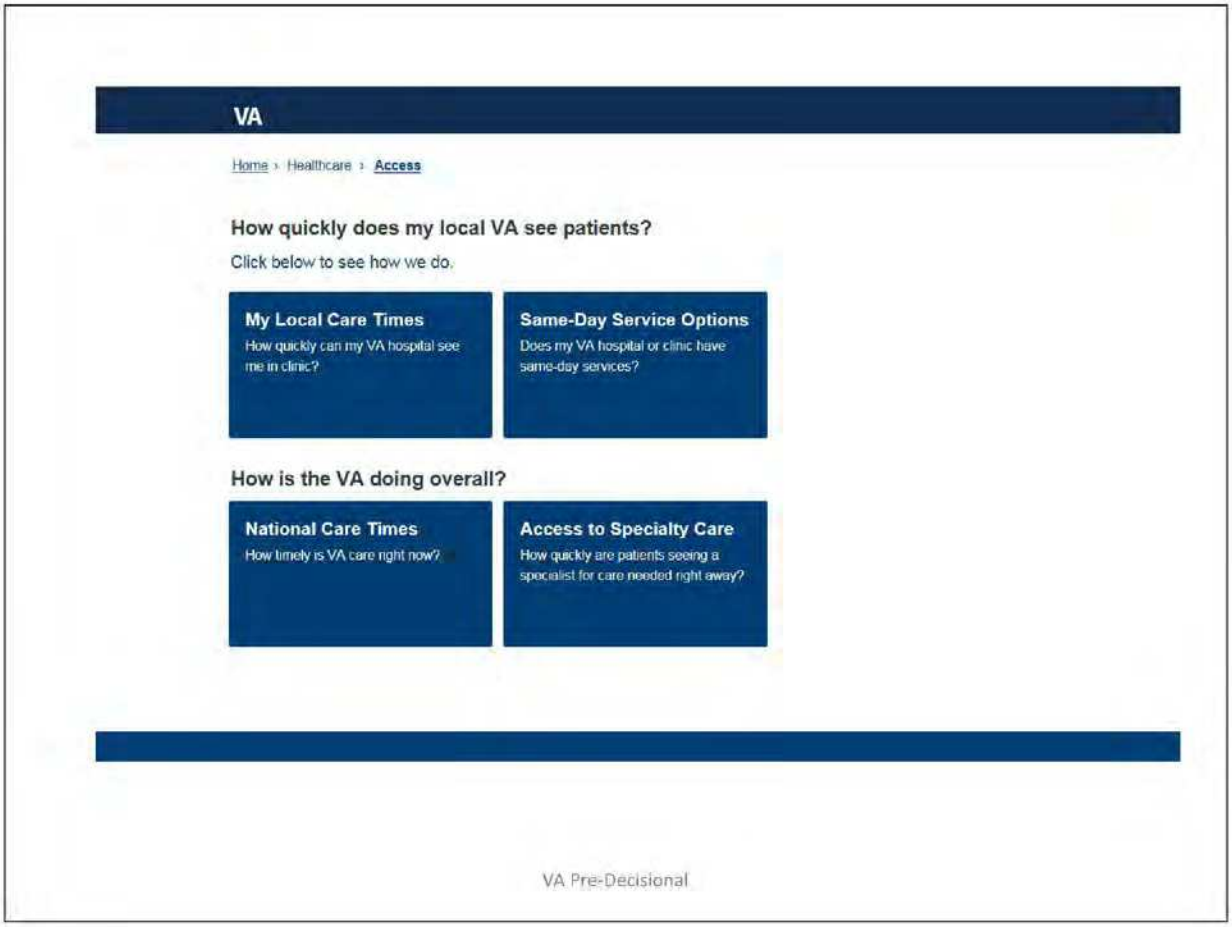
How quickly does my VA see patients?

How satisfied are veterans like me with the timeliness of their care?

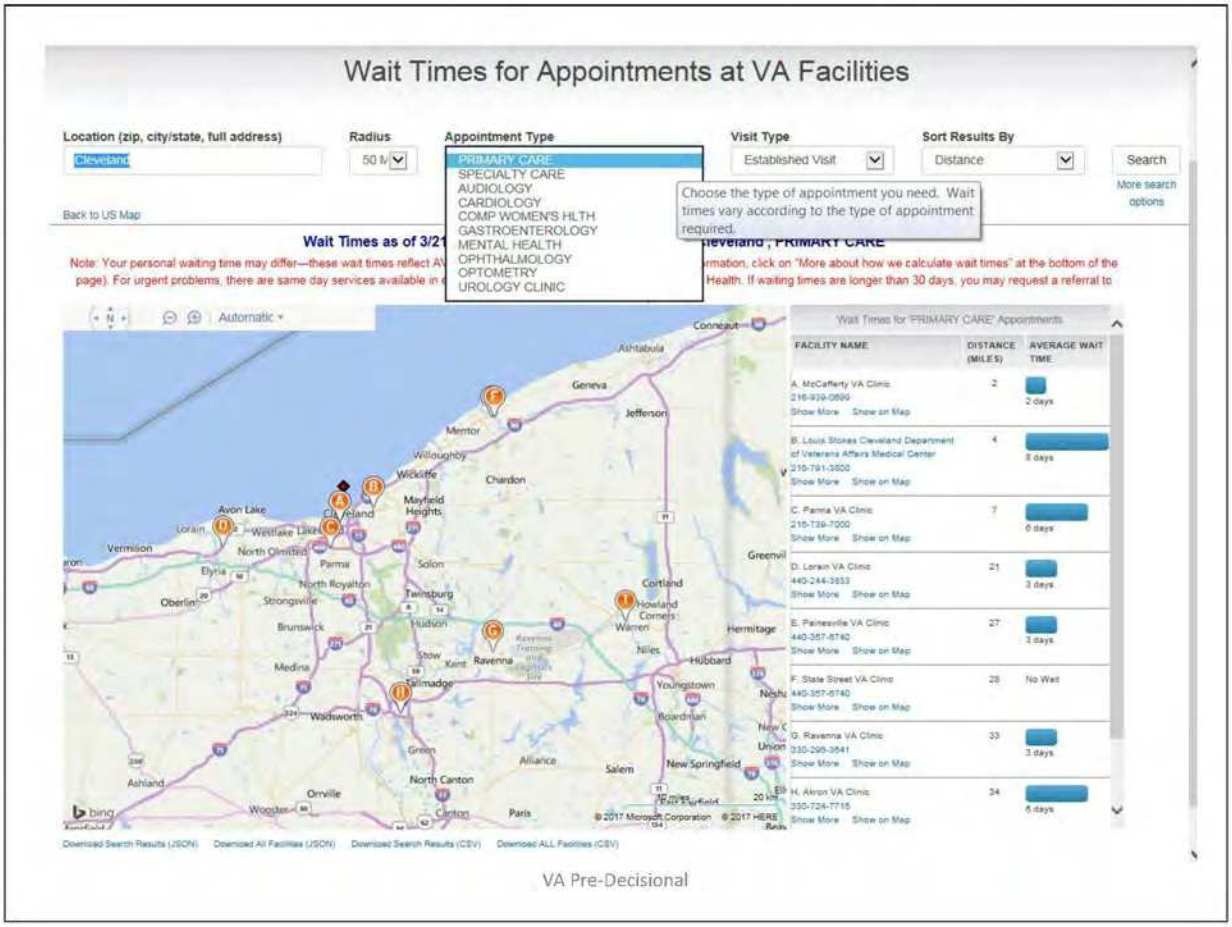
How well does my VA's care compare to other hospitals?

VA Pre-Decisional

AMERICAN OVERSIGHT

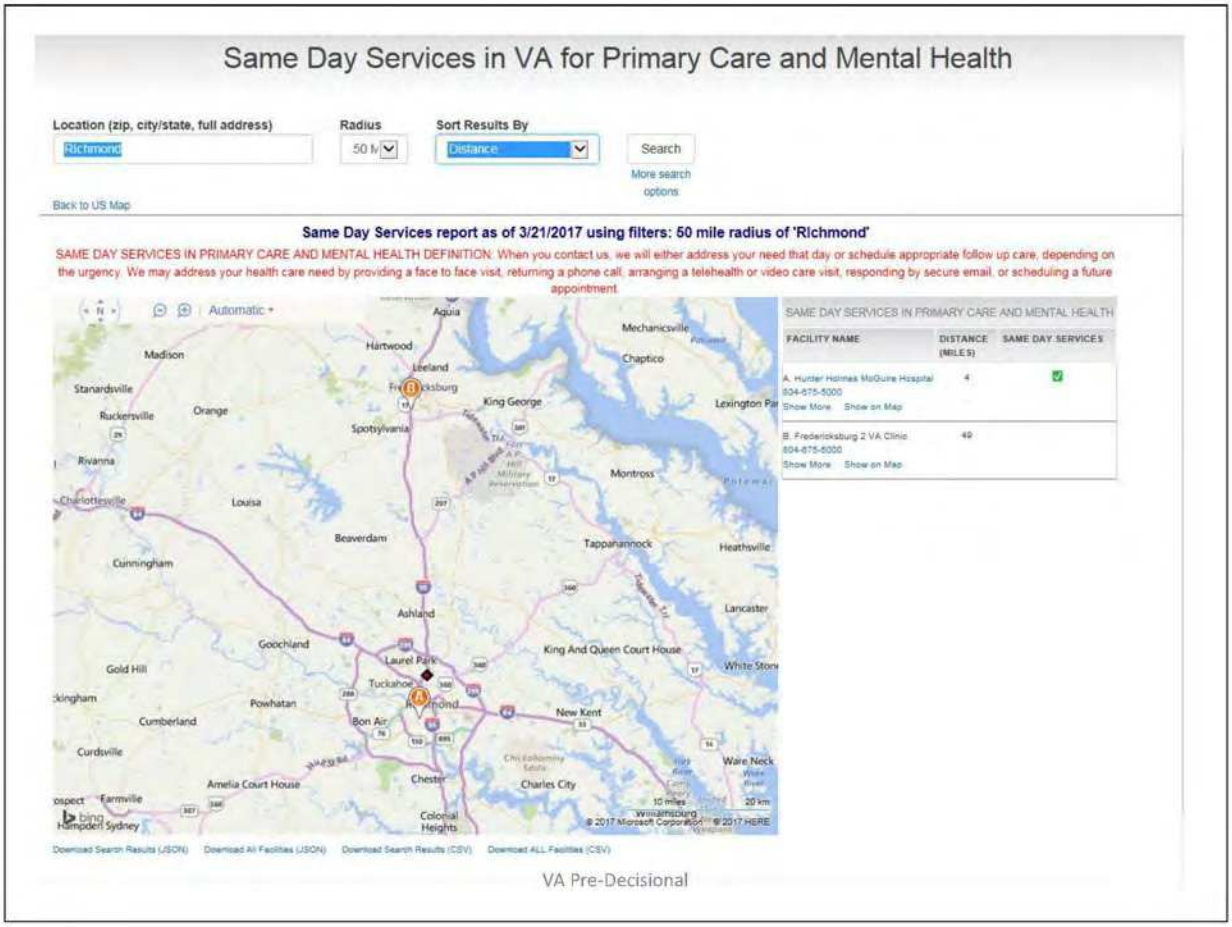


AMERICAN OVERSIGHT

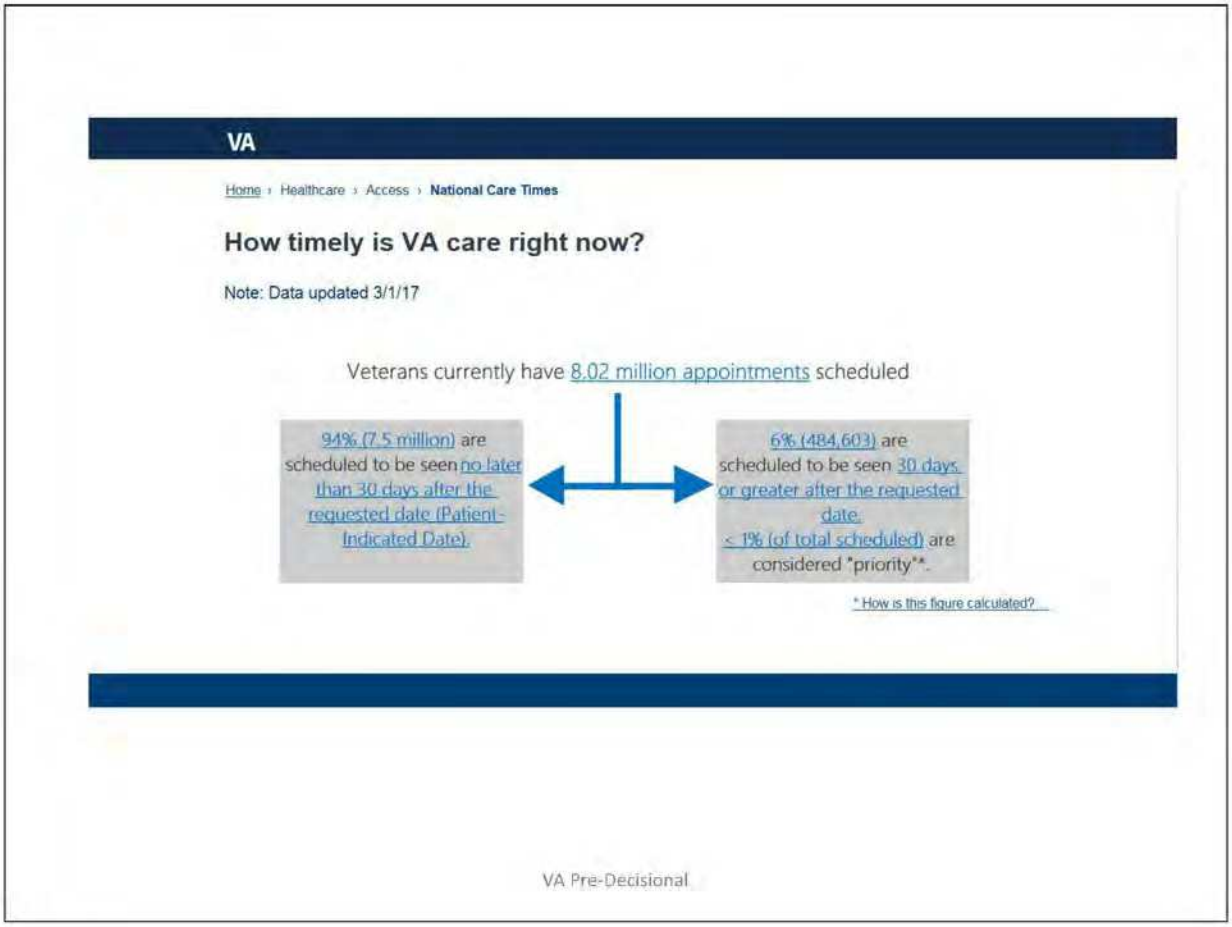


VA Pre-Decisional

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

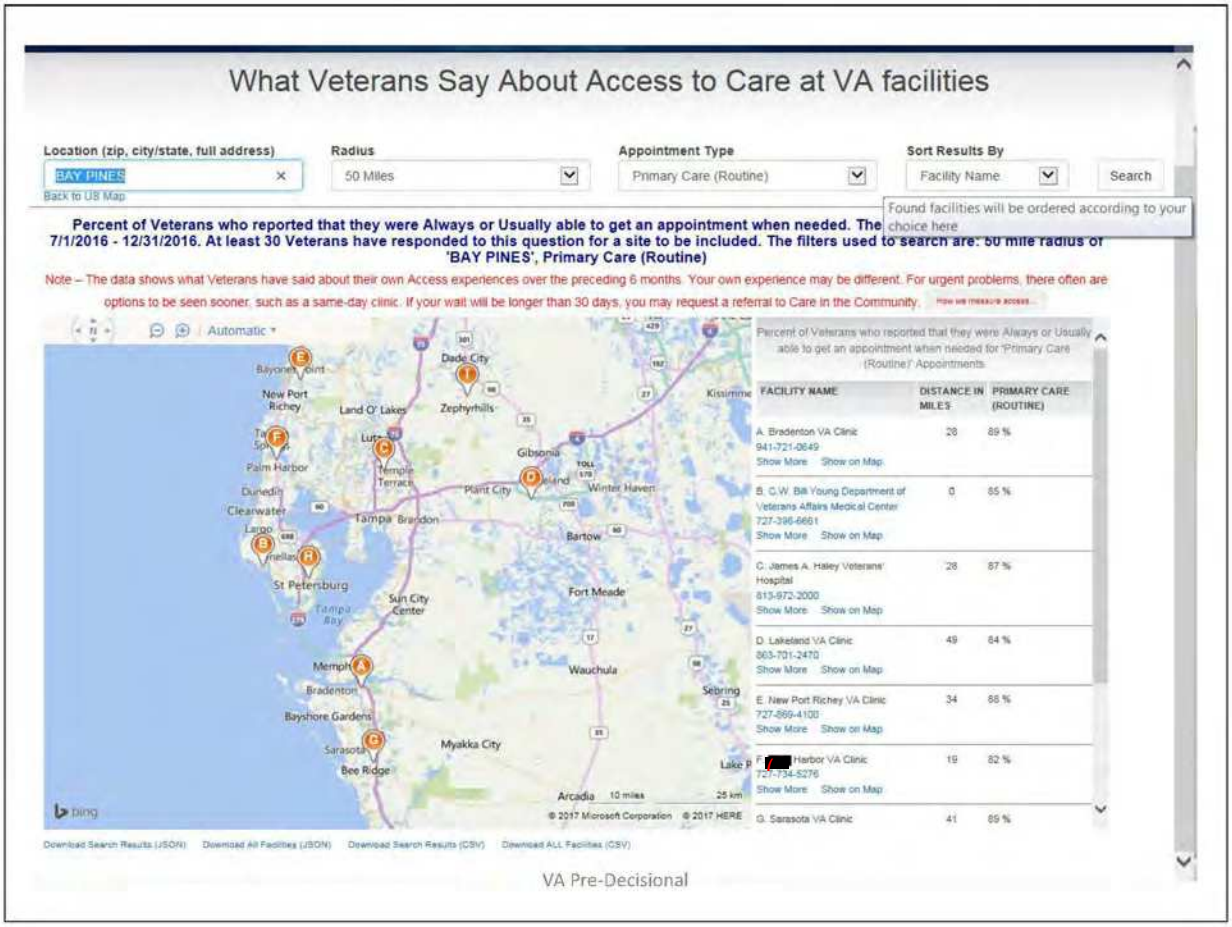


VA Pre-Decisional

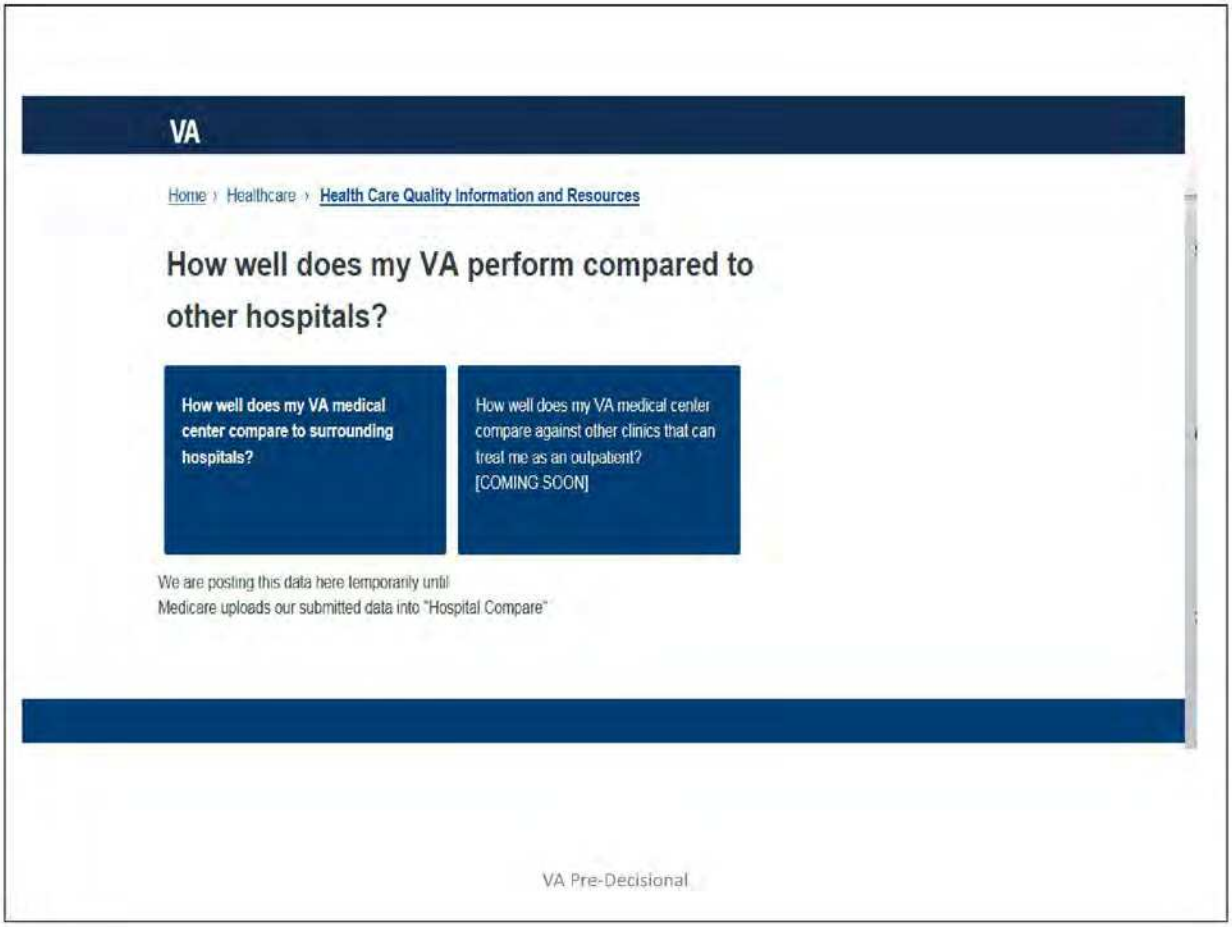
AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

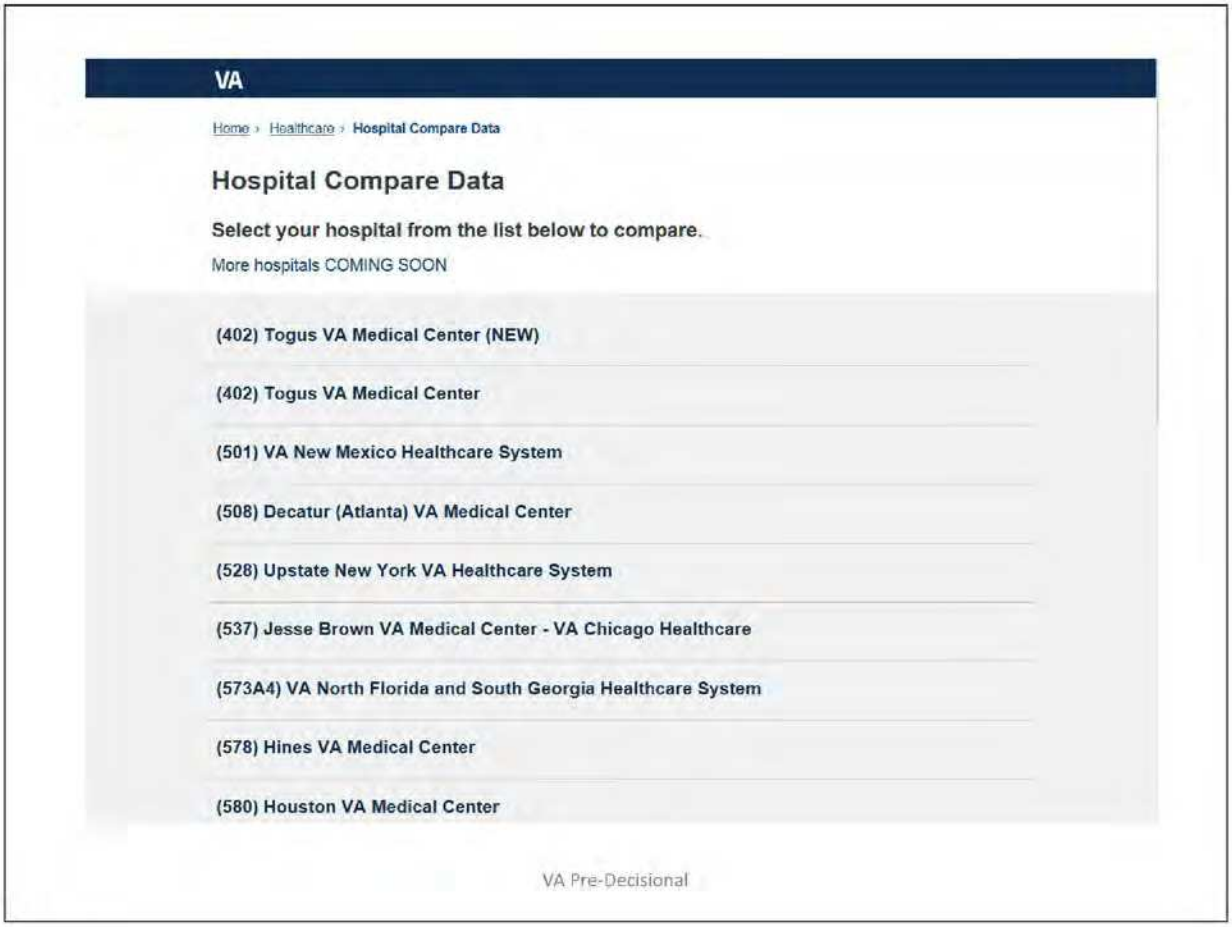


AMERICAN OVERSIGHT



VA Pre-Decisional

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Hospital Compare Data

Convert ▾ Select

Data date range (Preferred direction)	A wound that splits open after surgery on the abdomen or pelvis 7/13 - 6/15	Accidental cuts and tears from medical treatment 7/13 - 6/15	Blood stream infection after surgery 7/13 - 6/15	Broken hip from a fall after surgery 7/13 - 6/15	Collapsed lung due to medical treatment 7/13 - 6/15	Deaths among with serious c complication surger 7/13 - 6/15
National Average	2.32	1.43	10.21	0.06	0.41	136.48
National Median	2.2	1.4	9.8	0.1	0.4	135.6
Portland (HRR) Average	2.4	2.2	8.7	0.1	0.5	133.2
Portland (HRR) Median	2.2	1.6	9.6	0.1	0.4	137.3
National Top 10 Percent	1.98	0.92	8.00	0.06	0.32	114.35
National Top 25 Percent	2.13	1.14	9.04	0.06	0.36	124.46
(402) Togus VA Medical Center	4.52	1.67	6.41	0.00	0.00	0.00
BRIDGTON HOSPITAL	Not Available	Not Available	Not Available	Not Available	Not Available	Not Availa
CENTRAL MAINE MEDICAL CENTER	1.97	2.39	9.93	0.06	0.35	145.61
FRANKLIN MEMORIAL HOSPITAL	2.26	1.34	9.76	0.06	0.39	Not Availa
FRISBIE MEMORIAL HOSPITAL	2.19	1.48	9.45	0.06	0.36	Not Availa
INLAND HOSPITAL	2.27	1.38	9.72	0.06	0.39	Not Availa
MAINE MEDICAL CENTER	2.78	3.33	7.30	0.06	0.64	129.89
MAINEGENERAL MEDICAL CENTER	2.06	1.60	8.75	0.06	0.42	125.13
MEMORIAL HOSPITAL, THE	Not Available	Not Available	Not Available	Not Available	Not Available	Not Availa
MERCY HOSPITAL	2.12	2.07	9.64	0.06	0.33	121.38
MID COAST HOSPITAL	2.21	1.18	Not Available	0.06	0.40	Not Availa
PENOBSCOT BAY MEDICAL CENTER	2.22	1.61	9.46	0.06	0.47	Not Availa
RUMFORD HOSPITAL	Not Available	Not Available	Not Available	Not Available	Not Available	Not Availa
SOUTHERN MAINE HEALTH CARE	2.61	1.62	9.27	0.06	0.33	144.61
ST ANDREWS HOSPITAL	Not Available	Not Available	Not Available	Not Available	Not Available	Not Availa
ST MARYS REGIONAL MEDICAL CENTER	2.19	2.20	10.62	0.06	0.46	121.72
STEPHENS MEMORIAL HOSPITAL	Not Available	Not Available	Not Available	Not Available	Not Available	Not Availa
WENTWORTH-DOUGLASS HOSPITAL	2.12	1.85	10.31	0.06	0.46	145.25
YORK HOSPITAL	2.17	1.04	8.76	0.06	0.39	144.64

VA Pre-Decisional

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/25/2017 2:07:24 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

I didnt get the slides

From: David shulkin <Drshulkin@aol.com>
Sent: Saturday, March 25, 2017 10:00 AM
To: Poonam Alaigh
Cc: Bruce Moskowitz
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Confirmed

I sent slides

Sent from my iPhone

On Mar 25, 2017, at 8:46 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Bruce and David- confirming our conference call tomorrow at 11am. I will dial both of you in at that time.
>
> David, will you please send the slides to both of all of us- if you dont have them, I will try to get them today.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/25/2017 2:00:05 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Confirmed

I sent slides

Sent from my iPhone

On Mar 25, 2017, at 8:46 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

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> David, will you please send the slides to both of all of us- if you dont have them, I will try to get them today.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/25/2017 12:46:53 PM
To: Bruce Moskowitz [(b) (6) mac.com]; David Shulkin [drshulkin@aol.com]
Subject: Publicly Facing Transparency Website- Confirming call tomorrow at 11am

Bruce and David- confirming our conference call tomorrow at 11am. I will dial both of you in at that time.

David, will you please send the slides to both of all of us- if you dont have them, I will try to get them today.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 11:22:24 PM
To: (b) (6) R. (b) (6) [(b) (6) va.gov]
Subject: Fwd: Hopkins CIO
Attachments: (b) (6) pdf; Untitled attachment 06221.htm

Last one

Sent from my iPhone

Begin forwarded message:

> **From:** Bruce Moskowitz <(b) (6) mac.com>
> **Date:** April 7, 2017 at 7:19:34 PM EDT
> **To:** drshulkin@aol.com
> **Subject: Hopkins CIO**
>
> He now is in a private venture excellent to include

AMERICAN OVERSIGHT

[redacted] MSE, CIIP
[redacted]@jhmi.edu

[redacted]
Glen Burnie, MD [redacted]
(785) 218-[redacted]

CURRENT WORK:

[redacted] August 2011 - present

- [redacted]
- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

[redacted] January 2014 - present

[redacted]

- [redacted]
  - [redacted]

[redacted] September 2011 - present

[redacted]

- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

[redacted] December 2016 - present

[redacted]

- [redacted]

[redacted] July 2016 - present

[redacted]

- [redacted]

[redacted] June 2016 - present

- [redacted]

[redacted] February 2016 - present

- [redacted]

AMERICAN OVERSIGHT

PAST WORK:

(b) (6), (b) (2) July 2010 - August 2011

- (b) (6), (b) (2)

(b) (6), (b) (2)

- (b) (6), (b) (2)
  - (b) (6), (b) (2) September 2009 – May 2010
  - August 2009 – May 2010
  - June 2009 – September 2009
  - September 2009 – December 2009

(b) (6), (b) (2). March 2007 - May 2008

- (b) (6), (b) (2)

(b) (6), (b) (2) s

- (b) (6), (b) (2) e January 2008 - May 2008, January 2007 - May 2007
  - (b) (6), (b) (2)
- (b) (6), (b) (2) August 2004 - January 2005
  January 2005 - May 2006

EDUCATION:

(b) (6), (b) (2)

SKILLS:

- (b) (6), (b) (2)

AMERICAN OVERSIGHT

MEMBERSHIPS:

- (b) (6), (b) (2) [redacted]

ACHIEVEMENTS:

- (b) (6), (b) (2) [redacted]

PUBLICATIONS:

Peer-Reviewed Publications:

(b) (6), (b) (2) [redacted]

Abstracts:

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 11:22:07 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Hopkins CIO

Got it

Sent from my iPhone

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>
> <(b) (6) pdf>
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AMERICAN OVERSIGHT

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From: Bruce Moskowitz [(b) (6) mac.com]
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To: drshulkin@aol.com
Subject: Hopkins CIO
Attachments: (b) (6) pdf; Untitled attachment 06227.txt

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AMERICAN OVERSIGHT

[redacted] **MSE, CIIP**
[redacted]@jhmi.edu

[redacted]
Glen Burnie, MD [redacted]
(785) 218-[redacted]

CURRENT WORK:

[redacted] August 2011 - present

- [redacted]
- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]

[redacted] January 2014 - present

[redacted]

- [redacted]
- [redacted]

[redacted] September 2011 - present

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted] December 2016 - present

[redacted]

- [redacted]

[redacted] July 2016 - present

[redacted]

[redacted]

- [redacted]

[redacted] June 2016 - present

[redacted]

- [redacted]

[redacted] February 2016 - present

[redacted]

- [redacted]

AMERICAN OVERSIGHT

PAST WORK:

(b) (6), (b) (2) July 2010 - August 2011

- (b) (6), (b) (2)

(b) (6), (b) (2) September 2009 – May 2010
August 2009 – May 2010
June 2009 – September 2009
September 2009 – December 2009

(b) (6), (b) (2) March 2007 - May 2008

- (b) (6), (b) (2)

January 2008 - May 2008, January 2007 - May 2007

August 2004 - January 2005
January 2005 - May 2006

EDUCATION:

(b) (6), (b) (2)

SKILLS:

- (b) (6), (b) (2)

AMERICAN OVERSIGHT

MEMBERSHIPS:

- (b) (6), (b) (2) [redacted]

ACHIEVEMENTS:

- (b) (6), (b) (2) [redacted]

PUBLICATIONS:

Peer-Reviewed Publications:

(b) (6), (b) (2) [redacted]

Abstracts:

(b) (6), (b) (2) [redacted]

AMERICAN OVERSIGHT

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/9/2017 2:06:30 PM
To: (b) (6) hotmail.com
Subject: Re: Tough to do on the phone But..

your version is the final draft

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sun, Apr 9, 2017 10:02 am
Subject: Re: Tough to do on the phone But..

K- send me a initial final version if you can and I will forward on for a quick turn around by mid week at the latest. Trying to head home in the afternoon from the wedding stuff- if you can't get to coming up with a final draft, I will do it later. Also have scheduled a conference call in prep of the website stuff at 2pm today with the team and will give you an update accordingly

Sent from my iPhone

On Apr 9, 2017, at 9:36 AM, David Shulkin <drshulkin@aol.com> wrote:

> If you think it might be helpful- yes
>
> -----Original Message-----
> From: Poonam Alaigh <(b) (6) hotmail.com>
> To: David shulkin <Drshulkin@aol.com>
> Sent: Sun, Apr 9, 2017 9:02 am
> Subject: Re: Tough to do on the phone But..
>
> Do you want me to have Kate and her consultants do a quick review before making it official - I think we should
>
> Sent from my iPhone
>
> On Apr 8, 2017, at 7:02 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Good edits
> >
> > Sent from my iPhone
> >
> > On Apr 8, 2017, at 6:50 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
> >
> > Almost there- my edits in italics
> >
> > **Greater Choice for Veterans**
> > - *-Redesign* **the 40/30 Rule**
> > - **-Build a** *High Performing* **Integrated Network of Care**
> > - **- Empower veterans through transparency of information**
> >
> > **Modernize our System**
> > - **-Infrastructure Improvements and** *Streamlining*
> > - **-EMR Interoperability and** *IT* **Modernization**
> > - **Focus Resources More Efficiently**
> > - *-strengthening* **of Foundational Services in VA**
> > - **-VA/DOD/Community Coordination**

AMERICAN OVERSIGHT

- **-Deliver on Accountability and Effective Management practices**

Improve Timeliness of Services

- **Wait times and *Access* to Care**
- **Decisions on Appeals**
- **Performance on Disability Claims**

Suicide Prevention

Getting to Zero Suicides

Sent from my iPhone

On Apr 8, 2017, at 4:11 PM, David Shulkin <drshulkin@aol.com> wrote:

> revised to 5
>
> <priorities.pptx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/9/2017 2:02:46 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Tough to do on the phone But..

K- send me a initial final version if you can and I will forward on for a quick turn around by mid week at the latest. Trying to head home in the afternoon from the wedding stuff- if you can't get to coming up with a final draft, I will do it later. Also have scheduled a conference call in prep of the website stuff at 2pm today with the team and will give you an update accordingly

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> >
> > **Modernize our System**
> > - **-Infrastructure Improvements and *Streamlining***
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> > - **Focus Resources More Efficiently**
> > - **-*strengthening* of Foundational Services in VA**
> > - **-VA/DOD/Community Coordination**
> > - **-Deliver on Accountability and Effective Management practices**
>
> **Improve Timeliness of Services**
> **- Wait times and *Access* to Care**
> **- Decisions on Appeals**
> **- Performance on Disability Claims**
>
> **Suicide Prevention**
> *Getting to Zero Suicides*

AMERICAN OVERSIGHT

Sent from my iPhone

On Apr 8, 2017, at 4:11 PM, David Shulkin <drshulkin@aol.com> wrote:

> revised to 5
>
> <priorities.pptx>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/9/2017 1:36:29 PM
To: (b) (6) hotmail.com
Subject: Re: Tough to do on the phone But..

If you think it might be helpful- yes

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sun, Apr 9, 2017 9:02 am
Subject: Re: Tough to do on the phone But..

Do you want me to have Kate and her consultants do a quick review before making it official - I think we should

Sent from my iPhone

On Apr 8, 2017, at 7:02 PM, David shulkin <Drshulkin@aol.com> wrote:

> Good edits
>
> Sent from my iPhone
>
> On Apr 8, 2017, at 6:50 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Almost there- my edits in italics
> >
> > **Greater Choice for Veterans**
> > - *-Redesign* **the 40/30 Rule**
> > - **-Build a** *High Performing* **Integrated Network of Care**
> > - **- Empower veterans through transparency of information**
> >
> > **Modernize our System**
> > - **-Infrastructure Improvements and** *Streamlining*
> > - **-EMR Interoperability and** *IT* **Modernization**
> > - **Focus Resources More Efficiently**
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> >
> > **Suicide Prevention**
> > *Getting to Zero Suicides*
> >
> > Sent from my iPhone
> >
> > On Apr 8, 2017, at 4:11 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > revised to 5
> > >
> > > <priorities.pptx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/9/2017 1:02:41 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Tough to do on the phone But..

Do you want me to have Kate and her consultants do a quick review before making it official - I think we should

Sent from my iPhone

On Apr 8, 2017, at 7:02 PM, David shulkin <Drshulkin@aol.com> wrote:

> Good edits
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> > On Apr 8, 2017, at 4:11 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > revised to 5
> > >
> > > <priorities.pptx>

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/8/2017 11:03:21 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Tough to do on the phone But..

Ok
On Sat, Apr 8, 2017 at 7:02 PM David shulkin <Drshulkin@aol.com> wrote:
I like her edits - lets use these

Sent from my iPhone

Begin forwarded message:

> **From:** Poonam Alaigh <[redacted]hotmail.com>
> **Date:** April 8, 2017 at 6:50:56 PM EDT
> **To:** David Shulkin <drshulkin@aol.com>
> **Subject: Tough to do on the phone But..**

Almost there- my edits in italics

Greater Choice for Veterans

AMERICAN OVERSIGHT

- -*Redesign* **the 40/30 Rule**

- **-Build a**

High Performing **Integrated Network of Care**

- **- Empower veterans through**

transparency of information

<u>Modernize our System</u>

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Streamlining

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IT **Modernization**

AMERICAN OVERSIGHT

•**Focus Resources More Efficiently**

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- Decisions on Appeals

AMERICAN OVERSIGHT

- Performance on Disability Claims

Suicide Prevention

Getting to Zero Suicides

Sent from my iPhone

On Apr 8, 2017, at 4:11 PM, David Shulkin <drshulkin@aol.com> wrote:

revised to 5

AMERICAN OVERSIGHT

<priorities.pptx>

--
Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 11:02:32 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: Tough to do on the phone But..

I like her edits - lets use these

Sent from my iPhone

Begin forwarded message:

From: Poonam Alaigh <(b) (6) hotmail.com>
Date: April 8, 2017 at 6:50:56 PM EDT
To: David Shulkin <drshulkin@aol.com>
Subject: Tough to do on the phone But..

Almost there- my edits in italics

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Suicide Prevention
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revised to 5

<priorities.pptx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 11:01:56 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Tough to do on the phone But..

Good edits

Sent from my iPhone

On Apr 8, 2017, at 6:50 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

Almost there- my edits in italics

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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/8/2017 10:50:56 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Tough to do on the phone But..

Almost there- my edits in italics

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Suicide Prevention

Getting to Zero Suicides

Sent from my iPhone

On Apr 8, 2017, at 4:11 PM, David Shulkin <drshulkin@aol.com> wrote:

> revised to 5
>
> <priorities.pptx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 12:54:21 AM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: Important Sen Lee Intel

Got it

Thats what I figured
Im speaking toLee tommorow

Sent from my iPhone

> On Mar 30, 2017, at 8:14 PM, Darin Selnick <(b) (6) k@gmail.com> wrote:
>
> A friend of mine on the Hill talked to Sen Lee staff and just told me what the real problem is that is causing the hold on the Choice Act extension.
>
> He was told by Sen Lee staff that some VA career staff, a Sen Moran staffer and some Sen Isakson SVAC staff are saying that Choice 2.0 and all of the community care programs should have VA as primary payer.
>
> They also said that VA should not ever be the 2nd payer, including Choice.2.0. What has Sen Lee and staff concerned is that they were also told by this same Sen staff, that they want Section 2 in the bill so that it will be a precedent and a way to have VA be primary payer for Choice 2.0. Hearing that from the other Sen staff plus hearing from some VA staff that VA should be primary payer with Choice 2.0. is why they have kept the hold on the legislation. They are very concerned and have mixed signals from VA.
>
> To release the hold Sen Lee wants reassurance from you on two things:
> 1. To hear directly from you that you will not have VA be the primary payer for Choice 2.0.
> 2. For you to give him some written reassurances that VA will not be primary payer for Choice 2.0.
>
> I now understand why Sen Lee and his staff changed their tune after what they heard from other Sen Staff and VA staff.
>
> There is nothing we can do about Sen staff other than to educate them. I am very concerned that there are VA staff still saying about primary payer what you told them not to say.
>
> We will never get Choice 2.0 passed if we do not fix this.
>
> Darin
>
>

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) [redacted]@gmail.com]
Sent: 3/31/2017 12:14:05 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Important Sen Lee Intel

A friend of mine on the Hill talked to Sen Lee staff and just told me what the real problem is that is causing the hold on the Choice Act extension.

He was told by Sen Lee staff that some VA career staff, a Sen Moran staffer and some Sen Isakson SVAC staff are saying that Choice 2.0 and all of the community care programs should have VA as primary payer.

They also said that VA should not ever be the 2nd payer, including Choice.2.0. What has Sen Lee and staff concerned is that they were also told by this same Sen staff, that they want Section 2 in the bill so that it will be a precedent and a way to have VA be primary payer for Choice 2.0. Hearing that from the other Sen staff plus hearing from some VA staff that VA should be primary payer with Choice 2.0. is why they have kept the hold on the legislation. They are very concerned and have mixed signals from VA.

To release the hold Sen Lee wants reassurance from you on two things:
1. To hear directly from you that you will not have VA be the primary payer for Choice 2.0.
2. For you to give him some written reassurances that VA will not be primary payer for Choice 2.0.

I now understand why Sen Lee and his staff changed their tune after what they heard from other Sen Staff and VA staff.

There is nothing we can do about Sen staff other than to educate them. I am very concerned that there are VA staff still saying about primary payer what you told them not to say.

We will never get Choice 2.0 passed if we do not fix this.

Darin

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 10:35:35 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]

Great meeting today with Jared and the Department of Defense. Jared pushed hard and cut out what has been probably decades of red tape and we got to "yes" on finally working with DoD on electronic records. Its never been done before and if we can get this working it will be a game changer.

David

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/19/2017 10:25:27 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: No story now

3 am?

Sent from my iPhone

On Apr 19, 2017, at 3:01 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> You did it!!
>
> Sent from my iPhone
>
> On Apr 18, 2017, at 10:43 PM, David Shulkin <drshulkin@aol.com> wrote:
>
> > Between us
> >
> > Sent from my iPad
> >
> > Begin forwarded message:
> >
> > **From:** Donovan Slack <donovanslack@gmail.com>
> > **Date:** April 18, 2017 at 9:44:53 PM EDT
> > **To:** David Shulkin <Drshulkin@aol.com>
> > **Subject: No story now**
> >
> > I wanted, between us as always, to make sure not to leave you in limbo. Given everything, I decided it's not fair to do a story right now about what visn/vaco officials did or didn't do in three weeks leading up to last weeks PR crisis.
> > I would normally tell someone else this, who could relay it to you (ie: Linda), but honestly haven't found a person I feel comfortable with yet in your new orbit.
> > I'm sure I will at some point but didn't want to leave u hanging in the meantime.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/19/2017 10:16:21 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: No story now

Maybe (b) (6) can also be the one who is on point for both you and I for these critical and high visibility relationships- don't know that there is anyone else we can trust for these sensitive situations

Sent from my iPhone

On Apr 18, 2017, at 10:43 PM, David Shulkin <drshulkin@aol.com> wrote:

> Between us
>
> Sent from my iPad
>
> Begin forwarded message:
>
> > **From:** Donovan Slack <donovanslack@gmail.com>
> > **Date:** April 18, 2017 at 9:44:53 PM EDT
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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/19/2017 7:01:22 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: No story now

You did it!!

Sent from my iPhone

On Apr 18, 2017, at 10:43 PM, David Shulkin <drshulkin@aol.com> wrote:

> Between us
>
> Sent from my iPad
>
> Begin forwarded message:
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> > **From:** Donovan Slack <donovanslack@gmail.com>
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AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/19/2017 2:43:00 AM
To: Poonam Alaigh [(b) (6) hotmail.com]; Vivieca Simpson [(b) (6) gmail.com]
Subject: Fwd: No story now

Between us

Sent from my iPad

Begin forwarded message:

> **From:** Donovan Slack <donovanslack@gmail.com>
> **Date:** April 18, 2017 at 9:44:53 PM EDT
> **To:** David Shulkin <Drshulkin@aol.com>
> **Subject: No story now**
>
> I wanted, between us as always, to make sure not to leave you in limbo. Given everything, I decided it's not fair to do a story right now about what visn/vaco officials did or didn't do in three weeks leading up to last weeks PR crisis.
> I would normally tell someone else this, who could relay it to you (ie: Linda), but honestly haven't found a person I feel comfortable with yet in your new orbit.
> I'm sure I will at some point but didn't want to leave u hanging in the meantime.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 5/2/2017 11:56:28 AM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: drshulkin@aol.com; darin.selnick@va.gov; IP [(b) (6) frenchangel59.com]; L Perl [(b) (6) gmail.com]; mbs(b) (6) @gmail.com; (b) (6) aol.com
Subject: Re: Apple

Thanks - Darin, copying (b) (6) my Senior Advisor, on my end so that the two of you can be on point for us here at VA

Sent from my iPhone

> On May 2, 2017, at 7:37 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> I think the number one priority with Apple will be to have what they are already working on, portable health records available to Veterans. If they choose the choice program then we need to know in realtime what the evaluation and treatment is, not was or the cost can be prohibitive. Also the health provider needs important data from the VA records The 5 CEO's have committed resources also to get this done.
>
> We will need their assistance to have a patient centric program for preventive medicine that can also tract progress
>
> Tracking mechanism for opioid prescriptions within and outside of the VA
>
> Organize mental health early detection and treatment strategies. Currently there are too many unorganized initiatives and no feed back on effectiveness.
>
> Approved Choice services geotagged to the Veterans location hospitals, providers walk in clinics etc.
>
> The CEO's want to have their teams work with Apple for strategies to reduce health care costs. This is very important and we need to take advantage of everyone's intellectual capital.
>
> I am available to discuss 24/7 and the academic team is ready to move now.
>
>
>
>
>
>
> Sent from my iPad
> Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: [b) (6)] [[b) (6)]hotmail.com]
Sent: 3/29/2017 7:48:48 PM
To: David [drshulkin@aol.com]
Subject: Fwd:

U c this is her entertainment that she gets to do everything u do

Sent from my iPhone

Begin forwarded message:

> **From:** [b) (6)] <[b) (6)]gmail.com>
> **Date:** March 29, 2017 at 2:59:20 PM EDT
> **To:** [b) (6)] <[b) (6)]hotmail.com>
>
> Dr. Shulkin will probably be the only cool Secretary in history. I appreciate him very much, even when he keeps us on our toes.
>
> Today was fun. We left the WH at 12:14, Reggie got us to the airport by 12:23. We made our 12:50 flight. Yes! I of course ran to the gate like a crazy person I was determined to save the flight. Not needed, we made it. By far the best crazy experience ever...well except for meeting Barack and michelle, traveling to the Greek isles, etc. But it's up there :-)

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 4/8/2017 8:11:45 PM
To: (b) (6) hotmail.com
Attachments: priorities.pptx

revised to 5

AMERICAN OVERSIGHT

The Secretary's 5 Priorities

- Greater Choice for Veterans
  - -Revise the 40/30 Rule
  - -Build an Integrated Network of Care
  - - Empower veterans through transparency of information
- Modernize our System
  - -Infrastructure Improvements and Consolidations
  - -EMR Interoperability and Modernization
- Focus Resources More Efficiently
  - -Foundational Services in VA
  - -VA/DOD/Community Coordination
  - -Deliver on Accountability and Effective Management practices
- Improve Timeliness of Services
  - - Wait times and Accessibility for Care
  - - Decisions on Appeals
  - - Performance on Disability Claims
- Suicide Prevention

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/30/2017 12:06:10 PM
To: Ike Perlmutter [(b) (6) frenchangel59.com]; Laurie Perlmutter [(b) (6) gmail.com]; Bruce Moskowitz [(b) (6) mac.com]
Subject: Fwd: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

This morning on national public radio

> VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR
>
> http://www.npr.org/sections/health-shots/2017/03/30/521937557/the-va-is-on-a-path-toward-recovery-secretary-of-veterans-affairs-says

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/30/2017 12:05:04 PM
To: (b) (6) [(b) (6) hotmail.com]; (b) (6) [(b) (6) gmail.com]; (b) (6) gmail.com
Subject: Fwd: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

Sent from my iPhone

Begin forwarded message:

From: (b) (6) <(b) (6) gmail.com>
Date: March 30, 2017 at 5:29:19 AM CDT
To: drshulkin@aol.com
Subject: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

http://www.npr.org/sections/health-shots/2017/03/30/521937557/the-va-is-on-a-path-toward-recovery-secretary-of-veterans-affairs-says

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/30/2017 12:04:40 PM
To: [redacted] [redacted]sunnyshulkin.com]; [redacted] [redacted]sunnyshulkin.com]; [redacted] [redacted]gmail.com]
Subject: Fwd: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

Sent from my iPhone

Begin forwarded message:

From: [redacted] <[redacted]gmail.com>
Date: March 30, 2017 at 5:29:19 AM CDT
To: drshulkin@aol.com
Subject: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

http://www.npr.org/sections/health-shots/2017/03/30/521937557/the-va-is-on-a-path-toward-recovery-secretary-of-veterans-affairs-says

AMERICAN OVERSIGHT

Message

From: (b) (6) [(b) (6) gmail.com]
Sent: 3/30/2017 10:29:19 AM
To: drshulkin@aol.com
Subject: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

http://www.npr.org/sections/health-shots/2017/03/30/521937557/the-va-is-on-a-path-toward-recovery-secretary-of-veterans-affairs-says

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/29/2017 6:54:49 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Fwd: Problems at the WPB VA

Fyi- im handling

Sent from my iPhone

Begin forwarded message:

From: DJS <vacodjs1@va.gov>
Date: March 29, 2017 at 11:59:42 AM CDT
To: 'Shulkin ' <drshulkin@aol.com>
Subject: FW: Problems at the WPB VA

Sent with Good (www.good.com)

-----Original Message-----
From: (b) (6)
Sent: Wednesday, March 29, 2017 11:51 AM Eastern Standard Time
To: Shulkin, David J., MD
Subject: Problems at the WPB VA

Dear Dr. Shulkin,

I am writing to inform you of the problems at the West Palm Beach VAMC in regard to recruiting and retaining nurse practitioners.

For almost nine years I have been working as a psychiatric nurse practitioner at this facility. My duty station for the past 7 years has been in the PTSD clinic. It is an honor to care for veterans like my father whose lives were changed forever by the horrors of combat.

There are two issues of concern. First, there is a problem with recruiting NP's as the salary is not commensurate with the private sector. Second there is no mechanism to retain qualified NP's like myself. Despite having a doctoral degree and outstanding performance reviews, attempts to attain a step increase have been denied.

Here lies the problem. Once a nurse is "boarded" he/she cannot be "re-boarded." In 2008, I was "boarded" in an obsolete manner. Thus, I am literally "stuck" with a very low salary. In order to

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get "re-boarded" I was informed by HR that I must leave the VA for **one year** and then return. This policy does not make sense for a facility that has been struggling to recruit psychiatric nurse practitioners. To date, I believe we have 7 unfilled NP positions. Dr. Casariego, my immediate supervisor can verify how difficult it is to recruit NP's once they learn the salary. This shortage puts a strain on the existing staff. More importantly, it affects the veteran who gets shifted from provider to provider which results in poor of continuity of care.

Recently at a conference I learned that a 27 year old new graduate (who I trained) is earning $120,000 per year at a local facility. With my education and experience, nurse practitioners in the private sector are earning $150,000 - $160,000. I earn $98,107.00 after 34 years of being a nurse! It is quite disheartening that the VA devalues the contribution that NP's make in caring for our veterans.

Many people ask why I remain in such a low paying job. I tell them it is because I am devoted to my patients whom I have a long standing relationship with. However, the time has come that I must start looking after my best interests. As such, I am aggressively seeking employment in other government agencies.

Dr. Shulkin, we have a mutual acquaintance, Dr. Bruce Moskowitz, whom I have known for 30 years. He can vouch for my integrity. My efforts at the local level have been futile. I am hoping that during your administration you will find a way to rectify this inequitable pay scale system.

Respectfully,

(b) (6) [redacted] DNP, ARNP, PMHNP-BC

PTSD Clinic (1F-108)
(561) 422-(b) (6) [redacted]

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/30/2017 2:53:43 AM
To: Marc Sherman [(b) (6) gmail.com]
Subject: Re: AIPAC

Yes - i enjoyed meeting him

Sent from my iPhone

> On Mar 29, 2017, at 9:32 PM, Marc Sherman <(b) (6) mail.com> wrote:
>
> I heard that you spent some time with my friend (b) (6) at AIPAC. We played tennis tonight and he was telling me.
>
> Marc Sherman
> (202) 758-(b) (6)

AMERICAN OVERSIGHT

Message

From: Marc Sherman [(b) (6) gmail.com]
Sent: 3/30/2017 2:32:06 AM
To: David shulkin [drshulkin@aol.com]
Subject: AIPAC

I heard that you spent some time with my friend (b) (6) at AIPAC. We played tennis tonight and he was telling me.

Marc Sherman
(202) 758-(b) (6)

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/8/2017 1:35:40 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Google Alert - david shulkin

These were the rogue vaco employees that did this without our knowledge

When i found out i canceled it

I was looking to terminate these employees who are really crooked - havnt been able to do yet

Sent from my iPhone

On Apr 7, 2017, at 9:25 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> How did that happen- why would we give MVP data to a start up company - maybe I don't understand everything, but looks like a close call. You will have to fill me in on this
>
> Sent from my iPhone
>
> On Apr 7, 2017, at 5:35 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > See first articlE
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** Google Alerts <googlealerts-noreply@google.com>
> > **Date:** April 7, 2017 at 4:02:59 PM EDT
> > **To:** drshulkin@aol.com
> > **Subject: Google Alert - david shulkin**
> >
> > Google Alerts
> >
> > david shulkin
> > Daily update - April 7, 2017
> >
> > NEWS
> >
> > Home Ben's Blog Veterans Affairs Almost Gave Away Veteran MVP Genomic Data Russian ...
> > DisabledVeterans.org

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In a letter signed by then Under Secretary for Health **David Shulkin**, MD, the now VA Secretary canceled an a that would have allowed an ...

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The Situation Report: Is the CIO Job at VA About to Lose Its Influence?

MeriTalk (blog)

It is a truly stunning detail overlooked by most observers during the confirmation process of **David Shulkin** to I secretary of Veterans Affairs.

Flag as irrelevant

Trump: 'We Wouldn't Be Here If It Weren't For' Veterans [VIDEO]

Daily Caller

"They have not been taken care of properly. **David [Shulkin]**, who you know is the new secretary [of Veterans going to do a fantastic job." ...

Congress passes bill to save Veterans Choice Program - Beckley Register-Herald

VA to Expand Mental Health Care Eligibility to Discharged Veterans - Law Firm Newswire (press release)

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David Shulkin

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/8/2017 1:25:12 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Google Alert - david shulkin

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Sent from my iPhone

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> Sent from my iPhone
>
> Begin forwarded message:
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> **From:** Google Alerts <googlealerts-noreply@google.com>
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> **To:** drshulkin@aol.com
> **Subject: Google Alert - david shulkin**

Google Alerts

david shulkin

Daily update - April 7, 2017

NEWS

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/7/2017 9:24:27 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: Google Alert - david shulkin

See first articlE

Sent from my iPhone

Begin forwarded message:

From: Google Alerts <googlealerts-noreply@google.com>
Date: April 7, 2017 at 4:02:59 PM EDT
To: drshulkin@aol.com
Subject: Google Alert - david shulkin

Google Alerts

david shulkin

Daily update April 7, 2017

NEWS

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VA to Expand Mental Health Care Eligibility to Discharged Veterans - Law Firm Newswire (press release)

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/29/2017 12:38:52 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Meds

Sent from my iPhone

> On Mar 28, 2017, at 8:14 PM, (b) (6) <(b) (6) gmail.com> wrote:
>
> Sir,
>
> The agents wanted to build their emergency kit and came by to express the seriousness of the request in case something unforeseen happens.
>
> Do you have food allergies?
No
> Are you on any medications?
No

> Blood type?

Ill check
> Preferred foods to eat : I said salad, fish, poultry and vegetables. Snacks -mini pretzels, trail mix, granola bars.
> --

Sounds good
> Sent from Gmail Mobile

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Message

From: [redacted] [redacted]gmail.com]
Sent: 3/29/2017 12:14:29 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Meds

Sir,

The agents wanted to build their emergency kit and came by to express the seriousness of the request in case something unforeseen happens.

Do you have food allergies?
Are you on any medications?
Blood type?
Preferred foods to eat : I said salad, fish, poultry and vegetables. Snacks -mini pretzels, trail mix, granola bars.
--
Sent from Gmail Mobile

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 1:49:28 PM
To: Jennifer Lee [(b) (6) gmail.com]
Subject: Re: Next steps

Yes lets move this forward- i agree vivieca can help with the details

Sent from my iPhone

> On Mar 31, 2017, at 7:14 AM, Jennifer Lee <(b) (6) gmail.com> wrote:
>
> Hi David
> I would like to move forward with what we discussed earlier this week- I think the fastest route would be to begin as a detail? Would also allow me to keep working clinically at DC VAMC on weekends.
> What do you see as next steps? Should I discuss w Vivieca again?
> Thank you for the opportunity
> Jen
>

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Message

From: Jennifer Lee [(b) (6) gmail.com]
Sent: 3/31/2017 11:14:36 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Next steps

Hi David
I would like to move forward with what we discussed earlier this week- I think the fastest route would be to begin as a detail? Would also allow me to keep working clinically at DC VAMC on weekends.
What do you see as next steps? Should I discuss w Vivieca again?
Thank you for the opportunity
Jen

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 4:46:31 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Me and ma precious baby

Great picture!

Sent from my iPhone

> On Apr 3, 2017, at 11:21 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
>
>
> <IMG_0036.JPG>
>
>
>
> Sent from my iPhone

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/3/2017 3:21:48 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Me and ma precious baby
Attachments: IMG_0036.JPG; ATT00001.txt

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Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 2:01:56 AM
To: SreyRam Kuy [(b) (6) @gmail.com]
Subject: Re: Thank you!

Were working on opportunities

Thanks for your patience

Sent from my iPhone

> On Apr 3, 2017, at 11:36 AM, SreyRam Kuy <(b) (6) @gmail.com> wrote:
>
> Secretary Shulkin,
>
> It was such a pleasure getting to meet you a week ago. Thank you for
> chatting with me about my passion for excellence in healthcare for
> veterans.
>
> I would love the opportunity to serve on your executive leadership
> team at the VA. I believe my experiences leading medical efforts in
> Louisiana's Medicaid, which serves 1.6 million lives in a $10.7
> billion system, and my decade of experience working in the VA system
> can be valuable as a national VA healthcare executive leader.
>
> I've attached my CV, and if you would like to talk with some of my
> mentors, here are their contacts:
>
> Dr. Harlan Krumholz
> Board of Governors, PCORI
> Harold H Hines Professor of Medicine, Yale School of Medicine
> Phone: 203-641-2501
> Email: Harlan.Krumholz@yale.edu
>
> Dr. Elizabeth Bradley
> President-Elect, Vassar College
> Email: Elizabeth.Bradley@yale.edu (until June 30, 2017)
>
> Dr. Ramon Romero
> Chief, Surgical Service, Overton Brooks VA Medical Center
> Phone: 318-990-9674
> Email: Ramon.Romero@va.gov
>
> Dr. Quyen Chu
> Charles Knight, Sr Endowed Professor of Surgery
> Chief, Surgical Oncology, Louisiana State University – Shreveport
> Phone: 318-655-1358
> Email: qchu@lsuhsc.edu
>
> Again, thank you so much for all you do for our veterans. It inspires me.
>
> Respectfully, SreyRam
>
> SreyRam Kuy, MD, MHS, FACS
> Chief Medical Officer, Medicaid, Louisiana Department of Health
> RWJ Clinical Scholar, Yale 2007-2009
>
>
> On Tue, Mar 28, 2017 at 2:15 PM, Shulkin, David J., MD
> <David.Shulkin@va.gov> wrote:
> Thanks I enjoyed our meeting and your passion for this work
>
>> -----Original Message-----
>> From: SreyRam Kuy [mailto(b) (6) m@gmail.com]
>> Sent: Friday, March 24, 2017 4:43 PM
>> To: Shulkin, David J., MD; David shulkin
>> Subject: [EXTERNAL] Thank you!
>>
>> Secretary Shulkin,
>>
>> It was such a pleasure talking with you today, and thank you for taking the time to meet with me.

AMERICAN OVERSIGHT

>>
>> Here is the link to the "Save A Spot, Give a Slot to Your Battle Buddy" poster a veteran helped us design, as part of my initiative to reduce clinic no shows. Here is also the template of the letter sent to veterans. I would be honored if you utilized them.
>> https://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS
>> https://media.wix.com/ugd/04bfb6_bb75c2d33e714fadae596bd4a300f325.pdf
>> https://media.wix.com/ugd/04bfb6_096148d38d354faba5bba809a4bfb3a0.pdf
>>
>> Also, here's a link to the VA article about my work to reduce surgical mortality at the VA.
>> http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp
>>
>> Again, it was wonderful to get to meet you and Dr. Alaigh. Thank you so much for all you do for our veterans!
>>
>> I'll reach out again in 1 week. Thanks, -SreyRam
>>
>>
>> SreyRam Kuy, MD, MHS, FACS
>> Chief Medical Officer, Medicaid
>> Louisiana Department of Health
>> Phone: 210-535-(b) (6)
>> Email: (b) (6) @gmail.com
> <Dr. SreyRam Kuy CV - VA 2017.pdf>

AMERICAN OVERSIGHT

Message

From: SreyRam Kuy [(b) (6) @gmail.com]
Sent: 4/3/2017 3:36:50 PM
To: Shulkin, David J., MD [David.Shulkin@va.gov]; David shulkin [DrShulkin@aol.com]
Subject: Thank you!
Attachments: Dr. SreyRam Kuy CV - VA 2017.pdf

Secretary Shulkin,

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I would love the opportunity to serve on your executive leadership team at the VA. I believe my experiences leading medical efforts in Louisiana's Medicaid, which serves 1.6 million lives in a $10.7 billion system, and my decade of experience working in the VA system can be valuable as a national VA healthcare executive leader.

I've attached my CV, and if you would like to talk with some of my mentors, here are their contacts:

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Email: Elizabeth.Bradley@yale.edu (until June 30, 2017)

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Dr. Quyen Chu
Charles Knight, Sr Endowed Professor of Surgery
Chief, Surgical Oncology, Louisiana State University – Shreveport
Phone: 318-655-1358
Email: qchu@lsuhsc.edu

Again, thank you so much for all you do for our veterans. It inspires me.

Respectfully, SreyRam

SreyRam Kuy, MD, MHS, FACS
Chief Medical Officer, Medicaid, Louisiana Department of Health
RWJ Clinical Scholar, Yale 2007-2009

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> From: SreyRam Kuy [mailto(b) (6) m@gmail.com]
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> To: Shulkin, David J., MD; David shulkin
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> Secretary Shulkin,
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> Here is the link to the "Save A Spot, Give a Slot to Your Battle Buddy" poster a veteran helped us design, as part of my initiative to reduce clinic no shows. Here is also the template of the letter sent to veterans. I would be honored if you utilized them.
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> https://media.wix.com/ugd/04bfb6_bb75c2d33e714fadae596bd4a300f325.pdf
> https://media.wix.com/ugd/04bfb6_096148d38d354faba5bba809a4bfb3a0.pdf

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>
> Also, here's a link to the VA article about my work to reduce surgical mortality at the VA.
> http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp
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> Again, it was wonderful to get to meet you and Dr. Alaigh. Thank you so much for all you do for our veterans!
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> I'll reach out again in 1 week. Thanks, -SreyRam
>
>
> SreyRam Kuy, MD, MHS, FACS
> Chief Medical Officer, Medicaid
> Louisiana Department of Health
> Phone: 210-535-[redacted]
> Email: [redacted]@gmail.com

AMERICAN OVERSIGHT

SreyRam Kuy, MD, MHS, FACS

Medicaid Chief Medical Officer, Louisiana Department of Health

Associate Professor of Surgery, Louisiana State University – New Orleans

PROFILE:

- ✓ **As Chief Medical Officer of Louisiana Medicaid, I lead the state's drive to improve healthcare quality, engage healthcare providers and stakeholders in both managed care and fee for service systems, develop quality performance metrics and integrate cost effectiveness into a $10.7 billion health system which serves 1.6 million lives.**

- ✓ **Supervise staff members comprising the Quality Team, Pharmacy Team, Clinical Policy Team, Health Information Technology Team and Benefits & Covered Services Team.**

- ✓ **Advise the Secretary of Health on critical public health issues, communicate policies and vision to state legislators and the Governor and represent Medicaid to the media on issues ranging from opioids to zika and healthcare quality.**

- ✓ **Lead initiatives for emerging public health threats such as coordinating medical efforts at Flood Shelters, developing a Zika transmission prevention policy, and working with the Governor's office and state legislators to implement strategies tackling the opioid crisis.**

- ✓ **Oversee CMS grant for state Health Information Technology projects; including increasing EHR adoption among providers, ED discharge data linkage to primary care physicians, advancing a Telehealth network, implementing an EHR system in the Department of Corrections, and enabling providers to achieve meaningful use HIT.**

- ✓ **More than a decade of experience in the VA systems in Oregon, Texas, Connecticut, Wisconsin and Louisiana as a trainee, provider and administrator. Served as Assistant Chief of the General Surgery Section, Director of the Center for Innovations in Quality, Outcomes and Patient Safety, Chair of the Systems Redesign Committee and Board Member on the Quality, Safety and Value Board at Overton Brooks VA Medical Center. Worked with the Pentad on SAIL performance reports, HEDIS and Joint Commission ORYX core measures. Led initiatives to improve veterans' access to care through a 50% reduction in surgery clinic no shows.**

- ✓ **Worked to successfully decrease veteran mortality and reduce patient safety adverse events at Overton Brooks VA Medical Center. Developed biweekly provider educational series, broadcast remotely to outlying VA Community Based Outpatient Clinics in Louisiana and East Texas.**

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PERSONAL:

Office Address:	Louisiana Medicaid, Department of Health 628 North 4th Street, Baton Rouge, LA 70802
Mobile Telephone:	210-535-[redacted]
Office Telephone:	225-342-5381
Email Address:	[redacted]@gmail.com SreyRam.Kuy@LA.Gov
Citizenship:	United States

EDUCATION:

2017	Presidential Leadership Scholars Program *Nominated and selected to be a Presidential Leadership Scholar – a joint executive leadership training program by Presidents Bush and Clinton and run by the presidential centers of Lyndon B. Johnson, George H. W. Bush, William J. Clinton and George W. Bush*
2016	Healthcare Executive Leadership Program in Health Policy and Management *Heller School of Policy and Management, Brandeis University*
2009	M.H.S. (Master of Health Science) *Yale University School of Medicine, Robert Wood Johnson Clinical Scholar*
2005	M.D. (Medical Degree) *Oregon Health & Sciences University School of Medicine*
2000	B.S. (Bachelor of Science, Philosophy), magna cum laude *Oregon State University*
2000	B.S. (Bachelor of Science, Microbiology), magna cum laude *Oregon State University*

POSTGRADUATE TRAINING:

2009-2012	Residency, General Surgery (PGY 3-5) *Medical College of Wisconsin*
2007-2009	Robert Wood Johnson Clinical Scholar Fellowship *Yale University School of Medicine*
2005-2007	Residency, General Surgery (PGY 1-2) *University of Texas Health Sciences Center at San Antonio*

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APPOINTMENTS:

2016-present Chief Medical Officer, Medicaid, Louisiana Department of Health and Hospitals

As CMO of Louisiana Medicaid I lead the drive to improve healthcare quality, cost effectiveness and Health Information Technology in a $10.7 billion health system which serves 1.6 million lives in both managed care and fee for service systems. My work includes managing the Quality Team, Pharmacy Team, Clinical Policy Team, Health Information Technology Team and a Benefits & Covered Services Team. In addition, I lead initiatives for emerging public health threats such as coordinating medical efforts at Flood Shelters, developing a Zika transmission prevention policy, and working with the Governor's office and legislatures to implement strategies tackling the opioid crisis.

- Health Information Technology Team: lead the state's electronic health record adoption initiative and health information technology strategy, oversee CMS grant for Health Information Technology and a National Governors' Association HIT grant
- Quality Team: Develop and evaluate incentivized quality performance measures for providers & health plans to improve outcomes, safety, and quality of care for the state of Louisiana. Manage a Quality Team comprised of physicians, nurses & policy analysts addressing health care quality. Creation of a "Search by Score" site that promotes quality, transparency and adoption in Louisiana healthcare.
- Clinical Policy Team overseeing the evidence based approach for coverage of new benefits and services for Medicaid beneficiaries
- Benefits and Covered Services Team: manage all covered services and benefits in the Louisiana Medicaid system
- Pharmacy Team: overseeing Medicaid prescription coverage
- Rapidly respond to emergent public health issues (such as Zika virus, Opioid epidemic, drug shortages, flooding and emergency natural disasters) and develop guidance for providers and health plans
- Work with Louisiana healthcare stake holders, including Managed Care Organizations, hospital associations, healthcare providers, health facilities and institutions, patient advocacy groups to ensure high quality care for Louisiana's Medicaid population, and efficient use of resources

2014-2016 Director, Center for Innovations in Quality, Outcomes and Patient Safety, OBVAMC

- Develop and lead initiatives to meet Joint Commission ORYX core measures, SAIL performance measures, and monitor PSI occurrences.
- Develop programs that lead to sustained improvement in quality, outcomes and safety in the Surgical Services at the OBVAMC.
- Work on reducing mortality and adverse events profiled in the VA National Center for Patient Safety newsletter and website. Work on decreasing clinic no-shows featured in the Association of VA Surgeons newsletter and website.
- Collaborate with section chiefs to assess needs for quality improvement; develop, monitor and assess quality measures and initiatives; monitor

AMERICAN OVERSIGHT

analyze and assess surgical outcomes; integrate quality improvement tools and surgical outcome measures to create a cohesive program for the OBVAMC Surgical Services.

- Partner with VA clinical, policy and operational leaders to implement and evaluate different ways to make surgical healthcare safer, more effective and more affordable.

2015-2016 Assistant Chief, General Surgery Section
Overton Brooks VA Medical Center (OBVAMC)

- Integrate quality improvement tools and surgical outcome measures to create a cohesive program for General Surgery Section, leading to improved patient safety with a decrease in patient mortality and reduction in Critical Incident Network Tracking adverse events
- Work on SAIL and Joint Commission performance measures (pressure ulcer prevention, accidental puncture monitoring, smoking cessation/flu immunization documentation)
- Led initiative to improve veterans access to care through decreased surgery clinic no shows, with more than 50% reduction in clinic no shows
- Develop, monitor and assess quality and efficiency measures and initiatives for the General Surgery Section
- Monitor, analyze and assess surgical outcomes for the General Surgery Section
- Review Quality Improvement tools and surveys
- Collaborate with other section chiefs (Anesthesiology, ENT, General Surgery, ENT, Neurosurgery, Ophthalmology, Orthopedics, Podiatry, Urology, Vascular and Thoracic Surgery) to assess needs for a collaborative, comprehensive surgical care

2014-2016 Director, Surgical Services Grand Rounds Lecture Series, OBVAMC

- Developed a CME accredited academic curriculum for Grand Rounds Lecture Series; recruited local and national speakers
- Incorporated telecommunication to broadcast Grand Rounds Lectures remotely, available to outlying VA Community Based Outpatient Clinics (CBOCs) in Louisiana and Texas and also to employee's computer desktops to allow greater educational reach

2017-present Attending Surgeon, LSU Health – Perkins Surgery Center and Surgery Clinic

2017-present Associate Professor, Department of Surgery
Louisiana State University – New Orleans

2014-2016 Assistant Professor, Department of Surgery
Louisiana State University – Shreveport

2014-2016 Attending Surgeon, Overton Brooks Veterans Affairs Medical Center (OBVAMC)

AMERICAN OVERSIGHT

- Had highest RVU's and total number of cases in general surgery section
- Performed first laparoscopic assisted Low Anterior Resection at OBVAMC
- Developed a laparoscopic training course for residents, OR staff and surgeons; taught at OBVAMC and LSU

2014-2015 Consultant, Parkland Center for Clinical Innovation
Consultant on surgical site infection risk prediction modeling

BOARD CERTIFICATION
2014 American Board of Surgery # 059382

MEDICAL LICENSURE:
State of Texas # P9893 – Expiration 5/31/2017
State of Wisconsin #53724-20 – Expiration 10/3/2017
State of Tennessee #MD0000050960 – Expiration 3/31/2018
State of Louisiana #300710 – Expiration 3/31/2017

POSTGRADUATE COURSES:
10/2014 Cleveland Clinic, Advanced Laparoscopic Colorectal Master Class
11/2014 Florida Hospital, Laparoscopic General Surgery Master Class
7/2015 University of South Florida, Laparoscopic Colectomy Mini-Fellowship
9/2015 Methodist MITE, Advanced Hernia and Abdominal Wall Repair Master Class
2/2016 Life Cell, Complex Abdominal Wall Reconstruction Bioskills Lab

LEADERSHIP/HEALTHCARE POLICY TRAINING & EXPERIENCE:

American College of Surgeons Health Policy Award — June 12-18, 2016
"Leadership Program in Health Policy and Management" Executive Education Program at Brandeis University Heller School for Social Policy and Management.

American Medical Association Campaign School — 2013
Training in healthcare policy, legislation and politics in Washington, D.C.

American College of Surgeons Advocacy Grant — 2012

Robert Wood Johnson Clinical Scholar, Yale University School of Medicine — 2007 – 2009
Fellowship in healthcare policy & management, public health and research.

Healthcare Policy Synergy Workshop, Institute of Medicine. Washington, D.C. — 2008
Healthcare policy training, development of health disparities proposal

Robert Wood Johnson Foundation Cover the Uninsured Week Oregon Committee
Organized symposium on the uninsured in Oregon, speaker Governor Kitzhaber — 2003

American Academy of Family Physicians National Congress — 2000
Authored resolution on "Presentation of the AAFP Universal Health Care Coverage Task Force Report and Inclusion of Resident and Student Feedback

Kaiser Family Foundation Barbara Jordan Health Policy Scholar — 2000
Worked in Washington DC office of US Senator Tom Harkin. Wrote speeches on The Breast & Cervical Cancer Treatment Act and Re-authorization of the

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Older Americans Act, attended hearings, wrote briefs on prescription drug coverage, coverage for experimental studies, and healthcare instrument safety.

HEALTH POLICY PANELS/KEY NOTE SPEAKER/PRESENTATIONS

The Louisiana Story: Tackling Preterm Birth through Collaboration and Innovation — Dec 2016
CMS Quality Conference, Baltimore, MD

Achieving Viral Load Suppression through Collaboration – The Louisiana Story — Dec 2016
HIV Affinity Group National Conference, Washington DC

Medicaid Expansion and Access to Healthcare: Learning from Louisiana — Dec 2016
Louisiana Public Health Institute

Bridging the Gap Between Health Care and Health Equity — Oct 2016
National Academy for State Health Policy, Pittsburgh, PA

HIV Affinity – The Louisiana Story — Nov 2016
HIV Health Improvement Affinity Group National Webinar

Medicaid Industry Who's Who Series, "Mostly Medicaid" — Sept 2016
State Spotlight Series: Achieving Healthcare Quality

Medicaid Expansion and Improving Healthcare Quality in Louisiana — Sept 2016
American Association on Intellectual & Developmental Disabilities,Alexandria,LA

Panel Member: Using National Data Sources to Understand Healthcare Quality, Access and Disparities Among Women — 2015
AcademyHealth 2015 Annual Research Meeting, Minneapolis, Minnesota

Panel Member: Emerging Issues in Gender-Based and Women's Health. — 2009
AcademyHealth 2009 Annual Research Meeting, Chicago, Illinois.

Moderator, Robert Wood Johnson Alumni Careers in Health Policy. — 2008
Robert Wood Johnson Clinical Scholars National Conference, Washington, D.C.

Panel Member: The Many Avenues to Pursuing a Career in Health Policy. — 2007
Barbara Jordan Health Policy Scholars Conference, Washington, D.C.

TOWN HALLS

Town Hall Meeting — August 2016
Flood Recovery, Mold and Tetanus Vaccination, Mental Health Crisis Hotline

Town Hall Meeting — August 2016
Flood Recovery, Prescription Co-Pay Waivers, Early Refills for Prescriptions

Rotary Club of Shreveport — July 2016
Key Note Speaker: Medicaid Expansion

Shreveport Medical Society — July 2016
Key Note Speaker: Medicaid Expansion

COMMITTEE SERVICE AND ORGANIZATIONS

National Quality Forum — 2016-present
Medicaid Innovation Accelerator Committee

Alliance for a Healthier Generation — 2016-present
Obesity Prevention Task Force

Opioid Commission — 2016-present

Comparing Outcomes of Drugs and Appendectomy (CODA) — 2016-present
National Stakeholder Advisory Board

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National Academy for State Health Policy	2016-present
Public and Population Health Advisory Group	
AcademyHealth	2016-present
State Health Research and Policy Interest Group Advisory Committee	
American College of Surgeons	2016-2019
Committee on Diversity Issues	
Robert Wood Johnson Foundation Clinical Scholars Alumni Association	2016-2018
Co-President	
Chair, Medicaid Quality Committee	2016-present
Louisiana Commission on HIV, AIDS and Hep C	2016-present
Office of Public Health designee, appointed by Governor Edwards	
Louisiana Task Force on Telehealth Access	2016-present
Appointed by Secretary	
Executive Committee, Medicaid Evidence-based Decisions Project, Portland, OR	2016-present
Chair, Improving Veterans Access to Care Committee	2015
Board Member, Quality, Safety and Value Board, OBVAMC	2015-2016
Chair, Systems Redesign Committee, OBVAMC	2015-2016
Chair, General Surgery Faculty Recruitment Committee, OBVAMC	2015-2016
Federation of State Medical Boards (FSMB)	2015-2016
Appointed Representative to Accreditation Council for Continuing Medical Education Accreditation Review Committee (review accreditation for CME)	
National Board of Medical Examiners (NBME)	2011 – 2015
NBME Board Member	
Appointed by American Medical Association as one of 80 Board Members governing the NBME, overseeing a $100 million annual budget that governs the USMLE, the Post-Licensure Assessment System, and works with specialty boards to protect the public health.	
NBME Diversity and Inclusion Task Force	2013 – 2015
Tasked to improve diversity and inclusion in the executive leadership of the NBME and the USMLE exam contents.	
Association for Academic Surgery	
Membership Committee	2013 – 2015
Information and Technology Committee	2010 – 2012
Program Committee	2016 – present
Association of Women Surgeons, Communications Committee, Vice-Chair	2012 – 2014
Medical Society of Milwaukee County, Board of Directors	2012 – 2014
American Medical Association	
Chair, Wisconsin Resident & Fellow Governing Council	2011 – 2013
AMA Surgical Caucus, Executive Committee	2010 – 2011
Wisconsin Medical Society, AMA Resident Delegate	2010 – 2011
Robert Wood Johnson Clinical Scholars National Conference, Planning Committee	2008
Oregon Health & Science University Medical School First Year, Class President	2000 - 2001
Habitat for Humanity, Oregon State University Campus Chapter President	1988-1999
Science Student Council, President	1997-1998
Phi Eta Sigma National Honor Society, Oregon State University Chapter President	1997-1998
Oregon State University Undergraduate Senate, Senator	1997-1998

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Talons Women's Leadership & Service Honorary Society, Vice-President 1997-1998
Medical Careers Explorer Scouts, Corvallis Chapter President 1995-1996

PEER-REVIEWED PUBLICATIONS

1. **Kuy S**, Romero R. Decreasing 30 Day Surgical Mortality Utilizing the ACS NSQIP Surgial Risk Calculator. *Journal of Surgical Research. In Press*
2. **Kuy S**, Romero R. Eliminating Critical Incident Tracking Network Patient Safety Events at a Veterans Affairs Institution through Crew Resource Management Training. *American Journal of Medical Quality. In Press*
3. **Kuy S**, Romero R. Improving Staff Perception of a Safety Climate with Crew Resource Management Training. *Journal of Surgical Research. In Press*
4. **Kuy S**. Rapidly Growing, Bleeding Mass on a Golfer's Back. *JAMA Surgery. In Press*
5. **Kuy S**, Romero R, Rose K, Vincent L. Perineal Pain and Malodorous Drainage in a Rectal Cancer Patient. *BMJ Postgraduate Medical Journal. In Press*
6. Koo D, **Kuy S**, Ogunleye A, Sangji N. A Tradition of Advocacy in the American College of Surgeons: Protecting our patients, advancing our profession. *Bull Am Coll Surg. In Press*
7. Eskander M, Neuwirth M, **Kuy S**, Keshava H, Meizoso J. Technology for Teaching: New Tools for 21st Century Surgeons. *Bull Am Coll Surg. In Press*
8. **Kuy S**, Dua A, Rieland J, Cronin D. Cavernous Transformation of the Portal Vein. *Journal of Vascular Surgery.* 2016 Feb;63(2):529.
9. **Kuy S**, Jenkins P, Romero R, Samra N, Kuy S. The Rising Incidence and Mortality of Clostridium Difficile Associated Megacolon. *JAMA Surgery.* 2015 Oct 7:1-2.
10. **Kuy S**, Romero R, Kuy S. Gas Gangrene in a Diabetic Foot. *Journal of the Louisiana State Medical Society.* 2015 Sep-Oct;167(5):213-214. Epub 2015 Oct 15.
11. **Kuy S**. Carotid Body Tumor. *Journal of the Louisiana State Medical Society.* 2015 Jul-Aug;167(4):165. Epub 2015 Aug 15.
12. Busch K, Keshava H, **Kuy S**, Nezgoda J, Picou A. Teaching in the Operating Room: New Lessons for Training Surgical Residents. *Bull Am Coll Surg.* 2015 Aug;100(8):29-34.
13. Ogunleye A, Bliss L, **Kuy S**, Leichtle S. Political Advocacy in Surgery: The Case for Individual Engagement. *Bull Am Coll Surg.* 2015 Aug;100(8):40-4.
14. Dua A, **Kuy S**, Desai S, Heller J, Lee C. Diagnosis and Management of a Ruptured Mycotic Popliteal Pseudoaneurysm. *Vascular.* 2015 Aug;23(4):419-21
15. **Kuy S**, Dua A. Uncertainty in management of carotid stenosis in women – reply. *JAMA Surgery.* 2014;149(4):402-3.
16. **Kuy S**, Dua A, Desai S, Chappidi Rohit, Patel B, Seabrook G, Brown K, Lewis B, Rossi P, Lee C. The Increasing Incidence of Thromboembolic Events among Hospitalized Patients with Inflammatory Bowel Disease. *Vascular.* 2014 Jul 1.pii: 1708538114541799.
17. **Kuy S**, Dua A, Lee C, Patel B, Desai S, Dua A, Szabo A, Patel P. National Trends in Utilization of IVC Filters in the United States, 2000-2009. *Journal of Vascular Surgery: Venous and Lymphatic Disorders.* 2014 Jan;2(1):15-20.
18. Dua A, **Kuy S**, Lee CJ, Upchurch G Jr, Desai S. Epidemiology of Aortic Aneurysm Repair in the United States from 2000 to 2010. *Journal of Vascular Surgery.* 2014;59(6):1512-7.
19. Dua A, McMaster J, Desai P, Desai S, **Kuy S**, Mata M, Cooper J. The Association between Blunt Cardiac Injury and Isolated Sternal Fracture. *Journal of Cardiology Research and Practice.* 2014;2014:629687

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20. Dua A, Dua A, Jechow S, Desai S, **Kuy S**. Idiopathic Spontaneous Rupture of an Intercostal Artery. *Wisconsin Medical Journal*. 2014;113(3):116-8.
21. Dua A, Aziz A, Desai S, McMaster J, **Kuy S**. National Trends in the Adoption of Laparoscopic Cholecystectomy over 7 years in the United States and Impact of Laparoscopic Approaches Stratified by Age. *Minimally Invasive Surgery*. 2014;2014:635461.
22. **Kuy S**, Juern J, Weigelt J. Laparoscopic Primary Repair of Traumatic Intrapericardial Diaphragmatic Hernia. *Journal of Laparoscopic Surgeons* 2014;18(2):333-7.
23. **Kuy S**, Dua A, Rossi P, Seabrook G, Lewis B, Patel B, Lee C, Desai S, Brown K. Carotid Endarterectomy National Trends Over a Decade: Does gender matter? *Annals of Vascular Surgery*. 2013 Dec 6. pii: S0890-5096(13)00641-9.
24. Dua A, Desai SS, Dua A, Charlton-Ouw K, Dongerkery SP, Patel B, **Kuy S**, McMaster J, Darlow M, Shapiro ML. The Impact of Co-Morbid Conditions and Insurance Status on Trauma Patient Outcomes. *TRAUMA*. 2013, Vol. 15 Issue 3, p239
25. **Kuy S**, Rossi P, Seabrook G, Brown K, Lewis B, Rilling W, Martin G, Patel B, Dua A, McMaster J, Desai S, Lee C. Endovascular Management of a Traumatic Renal-Caval Arteriovenous Fistula in a Pediatric Patient. *Annals of Vascular Surgery*. Dec 2013. pii: S0890-5096(13)00472-X.
26. **Kuy S**, Dua A, Desai S, Dua A, Patel B, Tondravi N, Seabrook G, Brown K, Lewis B, Lee C, Kuy S, Subbarayan R, Rossi P. Surgical Site Infections Following Lower Extremity Revascularization Procedures Involving Groin Incisions. *Annals of Vascular Surgery*. 2013 Nov 1. doi:pii: S0890-5096(13)00423-8.
27. Dua A, Dua A, Desai S, Kuy S, Sharma R, Jechow S, McMaster J, Patel B, **Kuy S**. Gender Based Differences in Management and Outcomes of Cholecystitis. *American Journal of Surgery*. 2013 Nov;206(5):641-6.
28. **Kuy S**, He C, Cronin D. Renal Mucormycosis: A Rare and Potentially Lethal Complication of Kidney Transplantation. *Case Reports in Transplantation*. October 2013;2013:915423
29. McMaster J, Dua A, Desai S, **Kuy S**. Short Term Outcomes Following Breast Cancer Surgery in Pregnant Women. *Gynecologic Oncology*. 2013 Sep 13. doi:pii: S0090-8258(13)01177-3.
30. Kulaylat AN, Zheng F, **Kuy S**, Bittner JG. Early Surgical Specialization: a new paradigm. *Bull Am Coll Surg*. 2013 Aug;98(8):43-9.
31. Baker J, Misra S, Manimala NJ, **Kuy S**, Gantt G. The Role of Politics in Shaping Surgical Training. *Bull Am Coll Surg*. 2013 Aug;98(8):17-25..
32. **Kuy S**, Seabrook G, Rossi P, Lewis B, Dua A, Brown K. Management of Carotid Stenosis in Women. *JAMA Surgery*. 2013 Aug;148(8):788-90. Epub June 26, 2013.
33. Dua A, Patel B, **Kuy S**, Seabrook G, Tondravi N, Brown K, Lewis B, Rossi P. Asymptomatic 50–75% Internal Carotid Artery Stenosis in 288 Patients: Risk Factors for Disease Progression and Ipsilateral Neurological Symptoms. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013 Dec; 24(4):165-70. doi: 10.1177/1531003513491986.
34. Dua A, Patel B, Heller J, **Kuy S**, Dubose J, Tomasek JS, Larssen EM, Desai S. Variability in the Management of Superficial Venous Thrombophlebitis between Phlebologists and Vascular Surgeons. *Perspectives in Vascular Surgery and Endovascular Therapy*. 2013 Jun;25(1-2):5-10.
35. Desai P, Dua A, McMaster J, Patel B, Dua A, **Kuy S**, Desai S, Krzowski-Firych J. Infectious Mononucleosis-Like Syndrome Presented in Toxoplasmosis Infection. *J Surg Rad*. 2013:134-136.
36. **Kuy S**, Vickery M, Dua A, Rosner G. Appendiceal endometriosis mimicking appendicitis. *JAMA Surgery*. 2013 May 1;148(5):481.

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37. **Kuy S**, Somberg L, Paul J, Brown N, Saving A, Codner P. Undetected Penetrating Bladder Injuries Presenting as a Spontaneously Expulsed Bullet During Voiding: A Rare Entity and Review of the Literature. *Journal of Emergency Medicine*. 2013 May 25: S0736-4679(13)00356-9.
38. Dua A, Desai S, **Kuy S**, Patel B, Dua A, Desai P, Darlow M, Shirqavi J, Charlton-Ouw K, Shortell C. Predicting outcomes using the national trauma data bank: Optimum management of traumatic and blunt thoracic injury. *Perspectives in Vascular Surgery and Endovascular Therapy.* Sep;24(3):123-127, ePub: March 26, 2013.
39. **Kuy S**, Dua A, Desai SS, Baraniewski H, Lee C. Ruptured Mycobacterial Aneurysm of the Carotid Artery. *Perspectives in Vascular Surgery and Endovascular Therapy.* 2013;25(3-4):53-6.
40. Dua A, Desai S, McMaster J, Aziz A, Dua A, **Kuy S**. The Role of Platelets in Vascular Trauma Patients Compared to Patients with Chronic Vascular Disease. *Vascular Disease Management.* 2013;10(11):E240-E243.
41. **Kuy S**, Codner P, Guralnick M, Dua A, Paul J. Combined rectovesicular injuries from low velocity penetrating trauma in an adult. *Wisc Med J.* 2013;112(1):32-34.
42. **Kuy S**, Greenberg C, Gusani N, Dimick J, Kao L, Brasel K. Health services research resources for surgeons. *J Surg Res.* 2011;171(1):e69-73.
43. **Kuy S**, Sosa J, Desai R, Roman S, Rosenthal R. Age matters: A study of clinical and economic outcomes following cholecystectomy in elderly Americans. *Am J Surg.* 2011;201(6):789-796.
44. **Kuy S**, Roman SA, Desai R, Sosa JA. Outcomes Following Cholecystectomy in Pregnant and Non-pregnant Women. *Surgery*. 2009;146(2):358-366.
45. **Kuy S**, Roman S, Desai R, Sosa J. Outcomes following thyroid and parathyroid surgery in pregnant women. *Arch Surg*. 2009;144(5):399-406. Commentary by F Moore.
46. **Kuy S**. Stand up for patients. *Bull Am Coll Surg.* 2008;93(8):23-24.
47. Franks K, Li H, **Kuy S**, Kong W. Photodissociation of ICN at 266 nm and BrCN at 230 nm using brute force orientation. *Chemical Physics Letters*. 1999;302:151-156.

EDITORIALS/TECHNICAL NOTES/NEWSLETTER ARTICLES/MEDICAL BLOGS

1. **Kuy S,** Romero R, Cypher E. Shreveport: A Success Story. Creating a Culture of Safety at the Overton Brooks VA Medical Center. *Topics in Patient Safety. Veterans Affairs National Center for Patient Safety*. September 2014;14(5):1,4.
2. **Kuy S**. Profiles in Leadership. *Association of Women Surgeons Blog*. September 2014.
3. **Kuy S**. Health Services Research for Surgeons. *Association of Women Surgeons Website.* 2014.
4. **Kuy S**. Women Surgeon Leaders for the 21st Century. *Association of Women Surgeons Newsletter*. July 25, 2014
5. **Kuy S.** The Imperative to Improve Gallbladder Disease Treatment and Outcomes for Men. *Robert Wood Johnson Foundation Human Capitol Blog*. November 22, 2013.
6. **Kuy S.** Society for Vascular Surgery Trainee Advocacy Award Essay. *Society for Vascular Surgery* website. 2012.
7. **Kuy S**. Information & technology review: Online health resources for surgeons. *Association for Academic Surgery Newsletter*. Fall, 2010:6-7.

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8. **Kuy S**. Stand up for patients. *Los Angeles Times*. February 28, 2008.

BOOKS AND BOOK CHAPTERS

1. **Kuy S** (senior editor), Kwon R, Hochman M. 50 Studies Every Surgeon Should Know. Oxford Press. (Planned release 2017)
2. Provo B, **Kuy S**. Venous insufficiency ulcers. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2015, Philadelphia: Lippincott Williams and Wilkins.
3. Aljoudi M, Dua A, **Kuy S.** Cervical Bruit. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
4. Dua A, Aljoudi M, **Kuy S.** Absent or Diminished Pulse. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
1. Aljoudi M, McMaster J, **Kuy S.** Breast Cancer and Pregnancy. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.
2. Dua A, Desai S, **Kuy S.** Inguinal Mass. In Domino FJ (Ed.), The 5-Minute Clinical Consult 2016, Philadelphia: Lippincott Williams and Wilkins.

PRESENTATIONS

1. Reducing Surgery Cancellations in a Tertiary Hospital: A Three Year Review. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
2. Why We Don't Come to Clinic: Patient Perspectives. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
3. The Myth of Sisyphus: Is Reducing Surgery Clinic No-Shows Impossible? Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
4. It Takes a Village: Referring Providers Impact Patient No Shows. Association of VA Surgeons 2016 Meeting; Virginia Beach, VA April 2016.
5. Reducing Surgical Site Infections Utilizing a Prevention Bundle and a Multidisciplinary Approach at a Veterans Affairs Hospital. The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
6. Transformational Change: Creating a Culture of Safety in the Operating Room. Presented at: The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
7. Outlier to Leader: Designing a Risk Stratification Intervention to Decrease 30 Day Surgical Mortality in a Veterans Affairs Hospital. The American College of Surgeons NSQIP 2015 Meeting; Chicago, IL; July 2015.
8. Outlier to Leader: Designing a Risk Stratification Intervention to Decrease 30 Day Surgical Mortality in a Veterans Affairs Hospital. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
9. Transformational Change: Creating a Culture of Safety in the Operating Room. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
10. The Rising Incidence and Mortality of Clostridium Difficile Associated Megacolon. Presented at: The Association of VA Surgeons 2015 Meeting; Miami, FL; May 2015.
11. The Increasing Incidence of Thromboembolic Events Among Patients with Inflammatory Bowel Disease. Presented at: American College of Surgeons 2013 Clinical Congress; Washington DC; October 2013.

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12. Diagnosis and Management of a Ruptured Popliteal Mycotic Pseudoaneurysm. Presented at: Eastern Vascular Society. Sulfur Springs, West Virginia. September 21, 2013. (First Place Winner of the 2013 Resident Award)
13. Ruptured Carotid Mycotic Tuberculoid Aneurysm from Intravesical BCG. Presented at: Midwestern Vascular Surgical Society. Chicago, Illinois; September 8, 2013
14. Do women experience delays in carotid endarterectomy? Presented at: Society for Vascular Surgery Annual Meeting; San Francisco, California; May 31, 2013. (Winner of Sectional Poster Competition)
15. National trends in utilization of IVC filters over a decade in the United States, 2000-2009. Presented at: Society for Vascular Surgery Annual Meeting; San Francisco, California; May 31, 2013.
16. Surgical site infections and complications following vascular groin procedures. Presented at: Peripheral Vascular Surgery Society meeting; Park City, Utah; February 1, 2013.
17. Endovascular management of a traumatic renal-caval arteriovenous fistula in a pediatric patient. Presented at: International Symposium on Endovascular Therapy; Miami, Florida; January 22, 2013.
18. Carotid endarterectomy national trends over a decade: Does gender matter? Presented at: Midwestern Vascular Surgery annual meeting; Milwaukee, Wisconsin; September 6, 2012.
19. Asymptomatic 50-75% internal carotid artery stenosis in 288 patients: Risk factors for disease progression and ipsilateral neurological symptoms. Presented at: Midwestern Vascular Surgery annual meeting; Milwaukee, Wisconsin; September 6, 2012.
20. A study of clinical and economic outcomes following cholecystectomy in elderly Americans. Presented at: Department of Surgery grand rounds, Medical College of Wisconsin; Milwaukee, Wisconsin; June 10, 2010.
21. Predictors of in-hospital mortality following cholecystectomy among hospitalized patients. Presented at: 5th annual Academic Surgical Congress; San Antonio, Texas; February 3, 2010.
22. Predictors of in-hospital mortality following cholecystectomy. Presented at: American Medical Association 2010 research symposium; San Diego, California; November 5, 2010 (Honorable Mention Prize).
23. Outcomes following breast surgery in pregnant women. Presented at: 90th annual meeting of the New England Surgical Society; Newport, Rhode Island; September 13, 2009.
24. Outcomes following breast surgery in pregnant women. Presented at: Department of Surgery grand rounds, Yale University School of Medicine; New Haven, Connecticut; September 9, 2009.
25. Gender based differences in management and outcomes of cholecystitis. Presented at: AcademyHealth 2009 annual research meeting; Chicago, Illinois; June 28, 2009.
26. Gender based disparities in outcomes of cholecystitis. Presented at: New England science symposium; Boston, Massachusetts; April 3, 2009.
27. Women have better outcomes in cholecystitis. Presented at: American Medical Women's Association conference, Women's Health 2009, 17th Annual Congress; Williamsburg, Virginia; March 27-29, 2009.

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28. Outcomes following cholecystectomy in pregnant and non-pregnant women. Presented at: 4th Annual Academic Surgical Congress; Fort Myers, Florida; February 3-6, 2009.
29. Outcomes following thyroid and parathyroid surgery in pregnant women. Presented at: Robert Wood Johnson Clinical Scholars 2008 National Conference; Washington, D.C.; November 18-21, 2008.
30. Disparities in outcomes following thyroid and parathyroid surgery in pregnant and non-pregnant women. Presented at: Disparities in Surgical Care symposium; Boston, Massachusetts; Oct 27-28, 2008.
31. Outcomes following thyroidectomy and parathyroidectomy in pregnant women in the US, 1999-2005. Presented at: 89th annual meeting of the New England Surgical Society; Boston, Massachusetts; September 26-28, 2008.
32. Outcomes following thyroid and parathyroid surgery in pregnant women. Presented at: Department of Surgery grand rounds, Yale University School of Medicine; New Haven, Connecticut; September 24, 2008.
33. Are Drains Necessary After Craniosynostosis Surgery? American Society of Plastic Surgeons: Plastic Surgery Senior Residents Conference. Houston, Texas. March 17-19, 2005.
34. The Effects of Heat Treatment on Lactoferrin Concentration in Breast Milk. International Health Medical Education Consortium Conference. Havana, Cuba. March 12-15, 2002

JOURNAL REVIEWER

JAMA Surgery Reviewer	2016-present
Journal of Surgical Research Reviewer	2016-present
British Medical Journal Case Reports Reviewer	2014-present

TEACHING EXPERIENCE:

Louisiana State University – New Orleans, Associate Professor of Surgery	2017-present
Louisiana State University – Shreveport, Assistant Professor of Surgery	2014-2016
Lecturer, Surgery Resident SCORE Curriculum	2016
Lecturer, Third Year Medical Student Curriculum	2014-2016
Clinical Preceptor, First Year Medical Students	2014-2016
Yale University School of Medicine	
Course Facilitator, Introduction to Research	2007 – 2009
Oregon State University	
Teaching Assistant, General Microbiology	1999
Teaching Assistant, Introduction to Microbiology	1998 – 1999
Teaching Assistant, Biology	1997

HONORS, AWARDS & GRANTS

Early Career Achievement Award, Oregon Health & Sciences University, School of Medicine Alumni Association. 2017
Awarded to an alumnus who has made significant career contributions in improving health.

Presidential Leadership Scholar 2017

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Executive Leadership Training led by President Bush and President Clinton, held over 6 months onsite at the George H. W. Bush Presidential Center, William J. Clinton Presidential Center, George W. Bush Presidential Center & Lyndon B. Johnson Presidential Center.

American College of Surgeons Health Policy Scholar 2016
Award provides $8,000 grant, one of two general surgeons awarded to attend the "Leadership Program in Health Policy and Management" Executive Education Program at Brandeis University Heller School for Social Policy and Management.

Business Report's 2016 "Forty Under 40" Award 2016
Award in recognition of leadership, community service and career accomplishments

Ford Family Foundation Gerald E. Bruce Leadership & Community Service Award 2016
Award recognizing excellence in leadership & service, provides $5,000 grant which Dr. Kuy donated to a nonprofit serving veterans.

Certificate of Appreciation, Overton Brooks VA Medical Center 2015
Presented by Medical Center Director for work in promoting diversity, invited Keynote Speaker for VA's Asian Pacific American Celebration Month

Making a Difference Award, Overton Brooks VA Medical Center 2014
Recognition of excellence in clinical care

Certificate of Appreciation, Overton Brooks VA Medical Center 2014
Presented by Medical Center Director for Surgical Services' Achievement in Reducing Adverse Events and Mortality

American College of Surgeons Advocacy Travel Grant 2012

American Medical Association 2010 Research Symposium Honorable Mention Prize 2010

Medical College of Wisconsin Affiliated Hospitals (MCWAH) Research Award 2010

New England Surgical Society 89th Annual Resident Research Competition Award 2008

Robert Wood Johnson Foundation Clinical Scholars Fellowship. National award providing two years of training in health services research, Yale University School of Medicine 2007 – 2009

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Surgery Intern of the Year Award, Department of Surgery, University of Texas Health Sciences Center at San Antonio	2006
Oregon Health & Science University ROSE Award (Recognition of Outstanding Service and Excellence)	2001
Ralph Bosworth, MD Memorial Scholarship	2000
Dr. JoAnne J. Trow Woman of Distinction Award	2000
Waldo-Cummings Outstanding Student Award	2000
Phi Kappa Phi Honor Society Tunison Award	1999
OSU Department of Microbiology Mark H. MiddleKauf Scholarship	1999
OSU Department of Microbiology Joseph E. Simmons Scholarship	1999
OSU College of Agricultural Science Jesse Hanson Scholarship	1999
OSU College of Science Heitmeyer Scholarship	1996
Presidential Scholar	1996
Laurel G. Case, MD Memorial Scholarship	1996
Robert C. Byrd Honors Scholar	1996
Valedictorian, Crescent Valley High School	1996

NEWS ARTICLES:

Read about Dr. Kuy's work reducing mortality and patient safety adverse events profiled in the VA National Center for Patient Safety here: http://www.patientsafety.va.gov/features/Shreveport_A_Success_Story.asp

Read about Dr. Kuy's work improving veterans' access to care through clinic efficiency profiled by the Association of VA Surgeons here: http://www.avasnews.com/single-post/2016/05/16/REDUCING-NO-SHOWS

Read about Dr. Kuy's work at Louisiana Medicaid improving healthcare quality profiled by Mostly Medicaid here: http://www.mostlymedicaid.com/?p=1821

Read about Dr. Kuy's work with Medicaid Expansion to improve patient health profiled by Business Reports 40 Under 40 here: https://www.businessreport.com/article/forty-40-qa-sreyram-kuy

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GRANTS AWARDED:

Zero to Three Grant 2016
"Text4Baby"
$10,000 grant for Technical Assistance implementing Text4Baby, a program aimed at improving birth outcomes for pregnant women in Louisiana Medicaid.

National Governors Association Grant 2016
"Getting the Right Information to the Right Health Care Providers, at the Right Time- How States Can Improve Data Flow"
Awarded to Louisiana Medicaid's Health Information Technology Team, one of three states to receive this grant in the form of Technical Assistance

Centers for Medicare & Medicaid Services Grant 2016
"Louisiana's Health Information Technology (HIT) and Health Information Exchange (HIE) Implementation Advance Planning".
Support adoption and meaningful use of certified EHR technology activities, promote interoperability among EHRs, state HIEs and the Medicaid system; and provide for the design, development and implementation of the appropriate data infrastructure for FY 2017 and 2018.
Total grant awarded: $25,900,382

GRANT APPLICATION IN SUBMISSION

Submitted to PCORI 12/2016
"Provider-Targeted Strategies to Improve Patient-Centered Care for a Medicaid-Insured Population by Reducing Opioid Over-Prescribing and Increasing Provider Knowledge of Opioid Harms and Alternative Therapies for Chronic Non-Cancer Pain"

Principal Investigator:
SreyRam Kuy, MD, MHS, FACS (Louisiana Department of Health)

Total Project Cost: $4 million

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REFERENCES

Dr. Harlan Krumholz
Board of Governors, PCORI
Harold H Hines Professor of Medicine, Yale School of Medicine
Director, Yale Robert Wood Johnson Foundation Clinical Scholars Program
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Dr. Elizabeth Bradley
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Dr. Ramon Romero
Chief, Surgical Service, Overton Brooks VA Medical Center
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Phone: 318-990-9674
Email: Ramon.Romero@va.gov

Dr. Quyen Chu
Charles Knight, Sr Endowed Professor of Surgery
Chief, Surgical Oncology, Louisiana State University – Shreveport
Phone: 318-655-1358
Email: qchu@lsuhsc.edu

Dr. Ashley Ferraro
Associate Program Director of Pulmonary & Critical Care Medicine Fellowship
Overton Brooks VA Medical Center
Associate Professor, Louisiana State University – Shreveport
Phone: 816-591-9866

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/29/2017 11:21:29 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: POLITICO's Morning eHealth, presented by the Coalition to Protect America's Health Care: A new notion for telemedicine funding? — New studies build the case — Shuren promises 'black belt' regulatory excellence

Or hire (b) (6)

Sent from my iPhone

On Mar 29, 2017, at 6:13 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> Not at all- it's strange how (b) (6) has become our source of information about the VA- we will need to change things around here
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> Sent from my iPhone
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> On Mar 29, 2017, at 7:10 PM, David shulkin <Drshulkin@aol.com> wrote:
>
> > Did u know?
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** (b) (6) <(b) (6) nyu.edu>
> > **Date:** March 29, 2017 at 4:30:29 PM CDT
> > **To:** (b) (6) <drshulkin@aol.com>
> > **Subject: Fwd: POLITICO's Morning eHealth, presented by the Coalition to Protect America's Health Care: A new notion for telemedicine funding? — New studies build the case — Shuren promises 'black belt' regulatory excellence**
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> >
> > Sent from my iPhone
> >
> > Begin forwarded message:

AMERICAN OVERSIGHT

From: "Morning eHealth" <morningehealth@politico.com>
Date: March 29, 2017 at 10:06:20 AM EDT
To: <(b) (6) [redacted] nyu.edu>
Subject: POLITICO's Morning eHealth, presented by the Coalition to Protect America's Health Care: A new notion for telemedicine funding? — New studies build the case — Shuren promises 'black belt' regulatory excellence
Reply-To: "POLITICO subscriptions" <reply-fe9412747d65057d72-630302_HTML-778973872-1376319-0@politicoemail.com>

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From: David shulkin [Drshulkin@aol.com]
Sent: 3/29/2017 10:59:48 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Fwd: POLITICO's Morning eHealth, presented by the Coalition to Protect America's Health Care: A new notion for telemedicine funding? — New studies build the case — Shuren promises 'black belt' regulatory excellence

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/29/2017 2:26:04 AM
To: brucem(b) (6) @mac.com
CC: David Shulkin [drshulkin@aol.com]
Subject: Intro to R&D

Bruce - should I proceed with an introductory call with the R&D point of contact at the VA- if so will plan it in 2 weeks once I am back in the country

Sent from my iPhone

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 5/5/2017 5:43:40 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Va budget document

We need to define the specific actions- this comes out of our benefits part of VA that does not have strong leadership yet

Sent from my iPhone

> On May 5, 2017, at 1:24 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> Who will be assigned at the VA to get this on tract? We have a call with (b) (6) Tuesday to get him working on the DOD to assign someone in preventive medicine and early detection to the VA. I was surprised that the diabetes claims are so high and we should hold the DOD accountable. It seems that the DOD has to take more interest in the tremendous 100 billion that the VA has to spend on disability claims.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
>> On May 5, 2017, at 1:13 PM, David shulkin <Drshulkin@aol.com> wrote:
>>
>> Sounds promising Bruce
>>
>> Sent from my iPhone
>>
>>> On May 5, 2017, at 12:56 PM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>>
>>> This is the document that we should use to cut the budget and at the same time improve care.
>>> For instance on the call I was on today regarding the largest claim for disability which is tinnitus, over 120 million service men and women claimed this disability. We had the leading expert in the field on the call Dr. (b) (6) (b) (6) and we all agreed this does not make sense. Only a small number of these claims could have been on the battlefield and exposed to a situation that could cause tinnitus.
>>> Until we take a step back and find out what the DOD does in early detection and prevention coupled with what data the VA collects to find out the type of environment the claimant served in to apply for this disability we will have an even larger budget deficit next year.
>>> Since (b) (6) can attack the problem on the prevention side and detect who actually has the disease we should be able to lower the outlay for tinnitus. We should do the same for every category of disability payments.
>>> https://www.va.gov/budget/docs/summary/Fy2017-BudgetInBrief.pdf
>>>
>>>
>>> <Fy2017-BudgetInBrief.pdf>
>>>
>>>
>>>
>>> Sent from my iPad
>>> Bruce Moskowitz M.D.
>>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 5/5/2017 5:24:39 PM
To: David shulkin [Drshulkin@aol.com]
CC: mbs(b) (6)@gmail.com; IP [(b) (6)frenchangel59.com]; L Perl [(b) (6) gmail.com]
Subject: Re: Va budget document

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From: David shulkin [Drshulkin@aol.com]
Sent: 5/5/2017 5:13:44 PM
To: Bruce Moskowitz [(b) (6) mac.com]
Subject: Re: Va budget document

Sounds promising Bruce

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AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 5/5/2017 4:56:05 PM
To: drshulkin@aol.com; Poonam Alaigh [(b) (6) hotmail.com]
CC: IP [(b) (6) frenchangel59.com]; mbs(b) (6) @gmail.com; L Perl [(b) (6) gmail.com]
Subject: Va budget document
Attachments: Fy2017-BudgetInBrief.pdf; Untitled attachment 06497.txt

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Overview

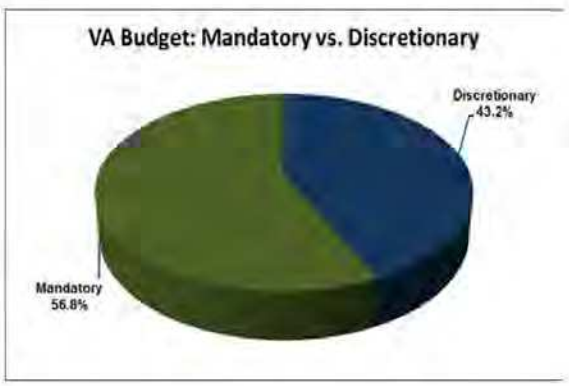
The 2017 Budget and 2018 Advance Appropriations (AA) requests for the Department of Veterans Affairs (VA) fulfill the President's promise to provide America's Veterans, their families, and Survivors the care and benefits they have earned through their service. The 2017 request for discretionary funding totals $78.7 billion (including collections); the mandatory funding request is $103.6 billion, of which $102.5 billion was previously provided via a 2017 Advance Appropriation. The 2017 request will support 366,544 Full-time Equivalent (FTE) employees. In addition, the 2018 AA request includes:

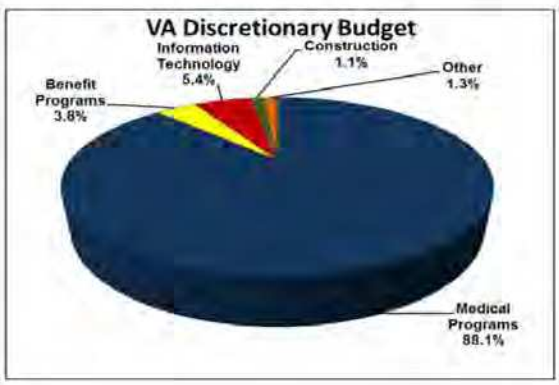
- $66.4 billion in discretionary funding for Medical Care; and
- $103.9 billion in mandatory funding for Veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities accounts).

The 2017 request will provide the necessary resources to meet VA's obligation to provide timely, quality health care and benefits to Veterans. It will allow VA to operate the largest integrated health care system in the country, delivering health care to approximately 9.2 million enrolled Veterans. Funding will provide for:

- A disability compensation benefits program for 4.4 million Veterans and 405,000 Survivors;
- A pension benefits program for 297,000 Veterans and 210,000 Survivors;
- The nation's tenth largest life insurance program, covering both active duty Service members and enrolled Veterans;
- An education assistance program serving nearly 1.1 million students;
- Vocational rehabilitation and employment benefits for nearly 141,000 Veterans;
- A home mortgage program with a portfolio of over two million active loans guaranteed by VA; and
- The largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter 132,093 Veterans and family members in 2017.

Department of Veterans Affairs
Discretionary and Mandatory Funding





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As of September 30, 2015, there were an estimated 22 million Veterans living in the United States and its territories and other locations. In addition to these Veterans, up to 25.7 million family members and dependents may be eligible for benefits from VA. The resources requested in this budget will allow VA to deliver on the Nation's promise to Veterans through investments in personnel, efficient business practices, and technology. VA will continue to work with its Federal, state, and local partners, including Veterans Service Organizations (VSO).

VA Staffing

Each day, more than 360,000 VA employees come to work for America's Veterans. These employees have a close connection with Veterans – over 32 percent are Veterans themselves. With this request and the resources provided by the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act), VA will see an increase of over 16,740 FTE in 2017 above the 2016 estimated level to expand access to health care and improve benefits delivery. This includes new FTE in the Veterans Benefits Administration (VBA) to improve the timeliness of non-rating claims, additional FTE in the Board of Veterans' Appeals (BVA) to address the appeals backlog, and more clinical FTE in the Veterans Health Administration (VHA), including physicians, nurses, and scheduling clerks.

Department of Veterans Affairs
Full-Time Equivalent Employees
By Administration and Office

	2015 Actual	2016 Estimate	2017 Request
Veterans Health Administration *	298,546	311,232	326,415
Veterans Benefits Administration	21,522	21,871	22,171
National Cemetery Administration	1,730	1,789	1,809
Office of Information Technology	7,309	7,631	8,334
General Administration	2,586	3,048	3,153
Board of Veterans' Appeals	646	680	922
Office of the Inspector General	676	721	821
Supply Funds	1,048	1,120	1,150
Franchise Funds	1,217	1,708	1,769
Total Veterans Affairs	**335,280**	**349,800**	**366,544**

Note: Total VA employees include actual and planned hires under the Choice Act.
* VHA FTE includes Medical Care, Medical Research, Veterans Choice Act, Canteen, Joint DoD-VA Medical Facility Demonstration Fund, and DoD-VA Health Care Sharing Incentive Fund.

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MyVA Transformation

MyVA puts Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider – a framework for modernizing VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. A Veteran walking into any VA facility should have a consistent, high-quality experience. To accomplish this, the Department has developed five strategies that are fundamental to the transformation in VA:

- Improving the Veterans' experience. At a minimum, every contact between Veterans and VA should be predicable, consistent, and easy. However, under MyVA, the Department is working to make each touch point exceptional.

- Improving the employee experience. VA employees are the face of VA. They provide the care, information, and access to benefits Veterans and their dependents have earned. They serve with distinction every day.

- Achieving support services excellence will let employees and leaders focus on assisting Veterans, rather than worry about back office issues.

- Establishing a culture of continuous performance improvement will apply lean strategies to help employees examine their processes in new ways and build a culture of continuous improvement.

- Enhancing strategic partnerships will allow the Department to extend the reach of services available for Veterans and their families.

To aid in the transforming of VA's culture, processes and capabilities, the Veterans Experience Office (VEO) was created with the mission of building trusted, lifelong relationships with Veterans, their families and supporters.

VEO will have three primary roles:

- Represent the voice and perspective of Veterans and their families in VA departmental governance.

- Design, implement and manage a portfolio of enterprise-level, customer-centric projects that will simplify customers' interactions with VA and help Veterans understand and access care and benefits provided by VA and their local communities.

- Support VA "mission owners" – those leaders responsible for delivering, day-in and day-out, VA care, services, and products to Veterans – in meeting their goals for improving customer experience.

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VA Strategic Goals

The investments requested in the 2017 Budget are essential to meet VA's mission to ensure Veterans have timely access to care and receive the best care and benefits possible. To track progress in meeting the needs of the Veteran – and to inform budget needs – VA uses its 2014 - 2020 Strategic Plan and Agency Priority Goals (APG).

Strategic Goal 1: Empower Veterans to Improve their Well Being
Strategic Goal 2: Enhance and Develop Trusted Partnerships
Strategic Goal 3: Manage and Improve VA Operations to Deliver Seamless and Integrated Support

The following examples show how VA is working to meet its Strategic Goals (SG):

Strategic Goal 1: Empower Veterans to Improve their Well Being. The following accomplishments are in support of SG 1:

- In 2015, VA has placed an estimated 64,902 Veterans in permanent housing, including moves into HUD–Veterans Affairs Supportive Housing (HUD-VASH)[1] Program, rapid rehousing placements through Supportive Services for Veteran Families (SSVF)[2] program, and moves from VA residential treatment programs into permanent housing. VA has also moved 87 percent of unsheltered Veterans out of unsheltered status within 30 days of engagement.

- VA has improved Veteran economic security through the VetSuccess On Campus (VSOC)[3] program, which helps Veterans succeed with on-campus assistance and counseling. There are currently 74 VSOC counselors at 147 campuses, with the potential to support a population of nearly 137,758 Veterans, Service members, and eligible dependents. VSOC counselors provide support in transition to campus life and work with Veterans to enable their education and employment success.

- VA established the MyVA Veterans Experience (VE) Office[4] in order to streamline VA presence and increase customer satisfaction through improvements in systems and processes. The VE office is currently working to improve services provided through VA's call centers with the goal of establishing a single point-of-contact phone number for all Veterans.

[1] http://www.va.gov/homeless/hud-vash.asp
[2] http://www.va.gov/homeless/ssvf.asp
[3] https://www.ebenefits.va.gov/ebenefits/vsoc-fact-sheet
[4] https://myva.va.gov/

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VA-19-0799-D-001536
DS_00003207

Strategic Goal 2: Enhance and Develop Trusted Partnerships. Following are examples of SG 2-related work:

- The Veterans' health and benefits portal, eBenefits, added 1,021,538 million individual accounts in 2015 and now has a total of 5,160,568 million enrolled, reaching the established 2015 target nearly two months ahead of schedule. Also, VA provides support to the Department of Defense (DoD) for the Integrated Disability Evaluation System (IDES) at 118 sites, with responsibility for completing 4 Core Process Steps within a goal of 100 days. As of September 30, 2015, VA was at 91 days and meeting the 100 day goal.

- VA has executed seventeen (17) active public-private partnerships, including those with Bob Woodruff, LinkedIn. and Coursera. Twenty-eight (28) additional local and national partnerships are currently in development, including partnerships that involve joint outreach and advocacy efforts, hiring/training commitments, enhancements to the VA's Veterans Employment Center (VEC), entrepreneurship cultivation, accelerated learning programs, cooperation with local communities, and other employment-related initiatives.

Strategic Goal 3: Manage and Improve VA Operations to Deliver Seamless and Integrated Support. Work to advance SG 3 in 2015 included:

- VA established the MyVA Employee Experience (EE) priority with the goal of improving the employee experience through a collaborative, inclusive experience that inspires and empowers all VA employees to deliver world-class customer service while demonstrating a sense of pride and achieving their full potential.

- To improve employee leadership training and engagement, VA launched the Virtual Aspiring Leaders[5] pilot program in November 2014 for employees levels GS-9 through GS-13, with a total of 151 participants. This online leadership development program helps develop the leadership skills of high-performing VA employees. It is meant to augment the Leadership VA program which had 76 fellows who graduated in September 2015.

- VA launched IT initiatives that center on improving Veteran outcomes. For example, Veterans can now access 7 new mobile apps[6]: Move Coach Mobile, Exposure Ed, Mobile Blue Button, Summary of Care, Launchpad, Airborne Hazards and Open Burn Pit Registry. Veterans using MyHealtheVet (MHV) can now receive appointment email reminders; view the last 45 days of shipped VA prescriptions, to include actual pill images; and receive email notifications when their VA prescriptions are shipped.

[5] http://mycareeratva.va.gov/library/leadership-va/leadership-development-programs/valp
[6] https://mobile.va.gov/appstore/all

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VA-19-0799-D-001537
DS_00003208

- VA stood up the MyVA Regionalization priority that creates an integrated plan for regionalization that will align VA's disparate organizational boundaries into a single regional framework to enhance internal coordination.

Through a collaborative, analytic process, VA has established the following four new APGs for 2016 - 2017, which will help inform our allocation resources to improve Veteran outcomes:

Agency Priority Goal 1: Improve Veterans Experience with VA
Agency Priority Goal 2: Improve VA's Employee Experience
Agency Priority Goal 3: Improve Access to Health Care as Experienced by the Veteran
Agency Priority Goal 4: Improve Dependency Claims Processing

To meet the APGs, VA is doing the following:

APG 1: Improve Veterans Experience with VA. VA offers a wide array of services and benefits to Veterans and eligible dependents; however, the experience is disjointed and inconsistent. There are hundreds of phone numbers and thousands of websites, each operating independently under different standards. The situation for facilities is no better. Veterans deserve better, as do VA staff, who care deeply about delivering the best possible outcome for Veterans.

The Veterans' Experience team is leading a powerful new effort to improve customer experiences across VA. Its goal is fostering the delivery of effective and easy customer experiences in which Veterans feel valued. VA is achieving this the same way the world's most successful companies do: by listening to our customers –Veterans, their families, and supporters – when they describe how they want things to work. Equally important, VA is listening to our employees about obstacles to excellence on-the-job. Employee empowerment is an essential part of the equation. This is a user-centered design putting Veterans and the employees who serve them, front and center.

Goal

Fulfilling our country's commitment to Veterans, VA will deliver effective and easy customer experiences in which Veterans feel valued.

By September 30, 2017, reach 90 percent agreement with the statement "I trust VA to fulfill our country's commitment to Veterans."

APG 2: Improve VA's Employee Experience. Leader and managerial actions can help boost job satisfaction and ultimately improve business outcomes. Strong leaders are important to creating a positive organizational climate. Employees who are regularly engaged with their leaders are more innovative than others, more likely to want to remain with their employer, absent less often, enjoy greater levels of personal well-being, and perceive their workload to be more sustainable than others. Our customer, the Veteran, will likely enjoy a higher level of satisfaction with VA services as a result of an improved employee experience.

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VA is committed to creating a work environment which provides all employees with a more consistent, positive employee experience, which ultimately improves the Veteran's experience with our organization. Studies indicate that employees who are satisfied with leadership behaviors provide a higher level of positive responses on employee surveys.

Goal

Improve VA's employee experience by developing engaged leaders at all levels, who inspire and empower all VA employees to deliver a seamless, integrated, and responsive VA customer service experience. Success by September 30, 2017 will be measured by a 3 percent or more increase in the "percent positive" responses by VA employees (over VA's 2015 baseline) to the following statements:

1) My supervisor provides me with constructive suggestions to improve my job performance.

2) In my work unit, steps are taken to deal with a poor performer who cannot or will not improve.

3) Employees have a feeling of personal empowerment with respect to work processes.

4) I feel encouraged to come up with new and better ways of doing things.

5) How satisfied are you with the information you receive from management on what's going on in your organization?

6) My organization's leaders maintain high standards of honesty and integrity.

APG 3: Improve Access to Health Care as Experienced by the Veteran. VA has experienced unprecedented growth in demand for its services as a result of better recognition of service-connected conditions; innovative and favorable clinical offerings for complex and costly health conditions; and the growing needs of an aging Veteran population. VA is also embedded within the larger U.S. health system, which is similarly experiencing increased demand for services and shortages of key clinical professions due to advances in technology and the aging of the population[7].

In 2015, a congressionally-mandated Independent Assessment of VA Health Care Capabilities[8] as well as an Institute of Medicine report[9] highlighted that VA access, while meeting timeliness standards *on average*, still had unacceptable levels of variation by site for specific services. These independent reviews are candid in stating that highly specialized services required by Veterans are frequently not available in their communities even from private sector providers.

[7] Rosenthal E. Long waits for doctors' appointments have become the norm. New York Times July 5, 2014.
[8] www.va.gov/opa/choiceact/factsheets_and_details.asp

[9] Institute of Medicine, Transforming Health Care Scheduling and Access. Washington: National Academies Press, 2015.

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Those independent reports interviewed many of U.S. medicine's thought leaders, and these experts highlighted the critical importance of addressing access challenges by taking a systems approach, and recommended strategies such as modeling system supply and demand relationships, exploring design and policy changes, and creating a culture of service excellence that empowers the front line to experiment, identify limitations, and learn from trials.

Goal

By September 30, 2017, Veterans will experience significant improvement in the ability of VA to provide appointments for needed care.

APG 4: Improve Dependency Claims Processing. It is VA's mission and responsibility to ensure benefits and services Veterans have earned are accurately accounted for and provided within a reasonable period of time. Since 2009, VA's Agency Priority Goal (APG) for improving access to benefits was focused on eliminating the backlog of disability claims, defined as the number of rating-related claims pending more than 125 days. VA has made dramatic progress in reducing the backlog, improving timeliness of decisions, and reducing the overall pending inventory of disability rating claims – while at the same time improving the quality of its decisions. To achieve these service improvements, VA defined the requirement, transformed claims processing through implementation of streamlined processes and systems, and accordingly focused resources on achieving the goal.

In addition to maintaining the progress made in timely adjudication of disability claims, VA will now add the additional focus on non-disability claims. Veterans who are awarded disability compensation at the 30-percent level or higher are entitled to additional compensation for their eligible dependents. Approximately 70 percent of the 4.1 million Veterans currently receiving compensation are eligible for this additional benefit – nearly 45 percent more than those eligible for the same benefits just five years ago. As the status of these Veterans' dependents change (through marriage, divorce, death, birth or adoption of children, step-children, and school attendance for children over 18 years of age), adjustments must be made to Veterans' compensation awards. With VA's record-levels of production of disability rating decisions (almost 1.4 million disability claims completed in 2015), more and more Veterans continue to be added to the compensation rolls. The result was an inventory at the end of 2015 of almost 227,000 pending dependency claims that have been waiting, on average, nearly a year.

Ensuring that Veterans receive timely and accurate claim decisions is paramount. As VA continues to improve timeliness of disability claims decisions, VA will also focus on the dependency claims that are the direct result of the dramatic increase in completed disability rating decisions and growth in the number of Veterans receiving compensation at the higher disability evaluation levels.

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Goal

Improve access to benefits and the customer experience for Veterans who are entitled to additional benefits for their dependents. By September 30, 2017, VA will reduce the overall inventory of dependency claims to 100,000 (a 56 percent improvement as compared to the 2015 baseline); and improve the average days to complete (ADC) for dependency claims from 221 days in 2015 to 125 days in 2017, a 43 percent improvement.

Business Process Improvements

The 2017 Budget proposes reforms and new business practices to make VA more efficient and effective, and improve services to Veterans. They include:

- ***Modernization of VA's Financial Management System***. VA has launched a multi-year effort to replace the outdated, 30-year-old core Financial Management System (FMS). VA is working with the Department of Treasury to pursue a shared service provider that will leverage existing infrastructure across government to support VA's financial needs. The end result will be a twenty-first century system that significantly improves the accuracy and transparency of VA's financial management. The 2017 Budget includes $52 million for FMS modernization ($44 million for IT and $8 million for General Administration).

- ***Simplified Appeals Initiative.*** VA's appeals system is complicated and ineffective, and Veterans wait too long for a final resolution of their appeal. On average, Veterans are waiting about 5 years for an adjudication of an appeal, with thousands waiting much longer. The 2017 Budget proposes a Simplified Appeals Process – legislation and resources (i.e., people, process, and technology) – that would provide Veterans with a simple, fair, and streamlined appeals process, in which they would receive a final appeals decision within 365 days from filing of an appeal by 2021. The 2017 Budget requests $156.1 million and 922 FTE for the Board of Veterans Appeals, an increase of $46.2 million and 242 FTE above the 2016 enacted level. This is a down payment on a long-term, sustainable plan to provide the best services to Veterans.

- ***Centralized Mail, the National Work Queue, and the Veterans Claims Intake Program (VCIP)*** are being implemented in VBA to increase the accuracy and efficiency of claims processing. The 2017 Budget provides $172.9 million for these activities, which will expedite claims processing, streamline processes for receiving digital records, and increase electronic processing capabilities.

- ***Telehealth.*** Telehealth funding supports the critical clinical, technological, and administrative infrastructure necessary for VA to successfully deliver virtual medical care to Veterans safely and cost-effectively. The 2017 Budget provides $1.2 billion for telehealth.

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- ***Geographic Information System.*** The 2017 Budget for the National Cemetery Administration (NCA) supports the use of a Geographic Information System (GIS) that will ensure the accuracy and accountability of remains within the Department's national cemeteries. GIS will help visitors with gravesite location and provide family members the confidence that all gravesites are cared for with the highest respect and dignity.

Investments in Information Technology

The 2017 Budget continues VA's investment in technology to improve the lives of Veterans. IT investments will enhance the systems that manage Veterans' health information and process benefits claims. As shown in the table below, this includes requested investments in Information Security ($370.1 million); the Veterans Health Information Systems and Technology Architecture (VistA) ($259.9 million); investments to Improve Veterans Experience ($171.3 million); and the Veterans Benefits Management System (VBMS) ($143.0 million).

Department of Veterans Affairs
Top IT Investments Supporting Care and Benefits for Veterans
(Obligations - $ in millions)

	2015 Actual	2016 Estimate	2017 Request
Information Security	209.7	180.3	370.1
VistA Evolution/Interoperability and VLER Health	327.0	232.6	259.9
Improve Veterans Experience	147.0	181.8	171.3
Veterans Benefits Management Systems	147.0	253.0	143.0
Virtual Lifetime Electronic Record (VLER)	10.1	0	0
VA Research Support	0	12.3	15.1
Other IT Development	67.8	155.2	198.8
IT Infrastructure (Hardware and Networks)	2,257.1	2,512.9	2,534.4

Note: Funding represents Development and Sustainment obligations by the Office of Information and Technology. It does not include any program funds that may also be supporting ongoing program management of the activity.

The Veterans Choice Act

On August 7, 2014, the President signed into law the Veterans Access, Choice, and Accountability Act of 2014. The Choice Act provides vital resources to increase Veterans' access to medical care while building infrastructure to ensure VA has the staff, facilities, and necessary support for a strong VA health care system. The Choice Act provides $5 billion in mandatory funding for VA to hire physicians and other medical personnel and improve VA's physical infrastructure. The Act also provides $10 billion in mandatory funding to establish a temporary program ("Veterans Choice Program") improving Veterans' access to health care by allowing eligible Veterans who meet certain wait-time or distance standards to use health care providers outside of the VA system. The Veterans Choice Program may provide a measure of short-term relief from the pressure of escalating health care requirements as some Veterans who would otherwise receive care in the VA health care system instead choose to participate in the new program, while also providing eligible Veterans with quick access to non-VA care.

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Department of Veterans Affairs
Veterans Choice Act Program Activity [1]

(Obligations - $ in 000s)

	2015 Actual	2016 Estimate	2017 Estimate	Total
Section 801				
Medical Services	609,715	1,415,001	821,597	2,846,313
Medical Support and Compliance	412	19,778	16,262	36,452
Medical Facilities	545,461	877,910	15,512	1,438,883
Subtotal	1,155,588	2,312,689	853,371	4,321,648
Information Technology	53,566	308,934	0	362,500
Minor Construction	97,522	102,500	115,830	315,852
Section 801 Total	**1,306,676**	**2,724,123**	**969,201**	**5,000,000**
Section 802				
Veterans Choice Act -Administration	322,057	100,000	158,441	580,498
Veterans Choice Act - Program	412,872	1,531,264	4,661,378	6,605,514
Information Technology Support	17,757	49,743	0	67,500
Emergency Hepatitis C	407,661	0	0	407,661
Emergency Care in the Community	2,338,827	0	0	2,338,827
Section 802 Total	**3,499,174**	**1,681,007**	**4,819,819**	**10,000,000**

***Note 1**: After the end of fiscal year 2015, external auditors advised VA to adjust its obligations downward by $1.7 billion for obligations which were either not closed or completely documented. Accordingly, VA made the adjustment, not reflected above, but will reverse it in 2016 to verify the accuracy of the audit estimates and recommendation.*

In 2017, VA will use the Choice Act funds in concert with annual appropriations to meet VA staffing and infrastructure needs and expand non-VA care to Veterans who are eligible for the Veterans Choice Program based on either: (1) distance to a VA facility; or (2) their wait time to see a VA medical professional. Specifically, VHA plans to spend $1.4 billion in 2016, and $853.4 million in 2017, to support the more than 9,700 new medical care staff hired through Choice Act resources, including those to administer the Veterans Choice Program. These staff include primary care, specialty care, and mental health care providers.

In addition to staffing, a key part of the Veterans Choice Act funding is allocated to improving VA facilities. Of these funds:

- $283.7 million will be for medical facility leases in 2016;
- Nearly $444.2 million will provide physical improvements for VA facilities through Non-Recurring Maintenance funds in 2016;
- $102.5 million will support Minor Construction projects in 2016 and $115.8 million in 2017, which will enhance Veterans access and improve patient privacy; and
- $131.8 million will fund Legionella prevention and control improvements in 2016.

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VA will also use $362.5 million of Veterans Choice Act funds for IT improvements, including $225.2 million for IT infrastructure and $136.9 million for IT development the Medical Appointment Scheduling System, and other IT development.

The following pages outline VA's 2017 budget request by appropriation account.

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Department of Veterans Affairs
Budget Authority, 2015-2017

Budget Authority
(dollars in thousands)

BA/Fund Account	2015 Actual	2016 Enacted	2017 Request
Federal funds:			
Benefit programs:			
Disability Compensation			
Disability Compensation	$73,364,345	$70,906,319	$79,770,017
Total Disability Compensation	73,364,345	70,906,319	79,770,017
Burial Mandatory Benefits	210,423	220,424	225,525
Pensions Mandatory Benefits	5,496,232	5,738,802	6,087,586
Economic Recovery Act (non-add)			
Subtotal, Compensation and Pension	**79,071,000**	**76,865,545**	**86,083,128**
Education Mandatory Benefits	13,838,679	12,941,285	14,875,646
Vocational rehabilitation and employment Mandatory Benefits	1,158,457	1,372,073	1,465,182
Vocational rehabilitation loan subsidy (non-add)	7	31	36
Subtotal, Readjustment Benefits	**14,997,136**	**14,313,358**	**16,340,828**
Insurance Mandatory Benefits	63,257	77,160	108,525
Housing Mandatory Benefits	459,807	509,008	0
Housing Program Original Loan Subsidy	404,521	345,814	584,088
Non-Appropriated Accounts			
Vocational Rehabilitation Upward Reestimate	113	78	0
Native American Veteran Housing	1,092	673	0
Housing Benefit Program fund Liquidating	-12,837	-11,971	-10,519
Trust Funds	908,687	846,812	756,558
General Post Fund	23,447	24,200	25,100
Proprietary receipts	-492,005	-574,137	-256,459
Intragovernmental transactions	-133	-110	-90
Total Benefits Mandatory	**95,424,085**	**92,396,430**	**103,631,159**
Veterans Health Administration (VHA):			
Medical and Prosthetic Research	588,513	630,735	663,366
Medical Programs:			
Medical Services 1/	45,041,948	49,721,986	45,039,208
Medical Care Collections Fund (MCCF)	3,422,806	3,515,171	3,558,307
Total Medical Services with MCCF	**48,464,754**	**53,237,157**	**48,597,515**
Community Care	**0**	**0**	**7,496,181**
Medical Support and Compliance 1/	5,788,131	6,116,595	6,495,794
Medical Facilities 1/	4,620,775	4,983,497	5,685,380
DoD-VA Health Care Sharing Incentive Fund	15,000	0	30,000
Joint DoD-VA Medical Facility Demonstration Fund	376,376	387,908	397,106
Medical Care Collections Fund (MCCF)	22,330	22,102	22,316
Total Demonstration Fund with MCCF	**398,706**	**410,010**	**419,422**
Total Medical Programs with MCCF	**59,287,366**	**64,747,259**	**68,724,292**
Total Medical Programs without MCCF	**55,842,230**	**61,209,986**	**65,143,669**
Total VHA with MCCF	**59,875,879**	**65,377,994**	**69,387,658**
Total VHA without MCCF	**56,430,743**	**61,840,721**	**65,807,035**
National Cemeteries Administration	256,630	271,220	286,193
Department Administration:			
General Administration	320,015	336,659	417,959
Board of Veterans' Appeals	99,180	109,884	156,096
Credit Reform - General Counsel (non-add)	*5,456*	*5,473*	*5,620*
VBA-GOE	2,531,900	2,707,734	2,826,161
Credit Reform - VBA (non-add)	*138,115*	*139,758*	*170,188*
Subtotal, GOE	**2,951,095**	**3,154,277**	**3,400,216**
Filipino Veterans Equity Compensation Fund	0	0	0
Office of Inspector General	126,686	136,766	160,106
Construction Major	692,000	1,282,851	528,110
Construction Minor	492,200	406,200	372,069
Grants for State Extended Care	90,000	120,000	80,000
Grants for State Cemeteries	46,000	46,000	45,000
Credit Reform	161,089	166,090	200,444
Information Technology 2/	3,895,070	4,126,205	4,270,958
Franchise Fund	-36,030	0	0
Total Departmental Administration	**8,418,110**	**9,438,389**	**9,056,903**
Total Budget Authority	**$163,974,704**	**$167,484,033**	**$182,361,913**
Total Mandatory	**$95,424,085**	**$92,396,430**	**$103,631,159**
Total Discretionary without MCCF	**$65,105,483**	**$71,550,330**	**$75,150,131**
Total Discretionary with MCCF	**$68,550,619**	**$75,087,603**	**$78,730,754**

(1) 2017 amounts do not include mandatory legislative proposals

1/ Amounts are post-transfer to the two joint VA-DOD accounts.

2/ Amount is post-transfer to the Joint DoD-VA Medical Facility Demonstration Fund

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Veterans Health Administration
Medical Care

Budget Authority - $ in 000s

	2015 Enacted	2016 Estimate	2017 Request	2018 Request
Medical Services	45,195,886	49,972,360	52,751,993	44,886,554
Medical Community Care				9,409,118
Medical Support and Compliance	5,874,091	6,144,000	6,524,000	6,654,480
Medical Facilities	4,737,000	5,020,132	5,723,000	5,434,880
Medical Care Collections Fund	3,422,806	3,515,171	3,558,307	3,627,255
TOTAL	**59,229,783**	**64,651,663**	**68,557,300**	**70,012,287**

Note: Excludes Veterans Choice Act funding. Includes all rescissions. Excludes transfers to the two joint Department of Defense (DoD)-VA health care accounts.

In 2017, VA will expand Veteran access to medical care by increasing medical and clinical staff, improving its facilities, and expanding care provided in the community. The 2017 Budget requests $68.6 billion for Veterans' medical care, an increase of $3.9 billion (6 percent) above the 2016 level. The 2017 Budget requests an additional $1.7 billion above the previously enacted 2017 AA. The 2017 request will support 313,249 medical care FTE, an increase of 10,420 FTE (3.4 percent) above the 2016 level.

FTE

	2015 Enacted	2016 Estimate	2017 Request	2018 Request
Medical Services	216,337	227,358	236,520	223,016
Medical Support and Compliance	49,479	51,250	52,520	52,350
Medical Facilities	23,644	24,221	24,209	24,209
TOTAL	**289,460**	**302,829**	**313,249**	**299,575**

Note: FTE include staff funded through Section 801 of the Choice Act.

VHA provides a broad range of primary care, specialty care, and related medical and social services. To meet the needs of our currently growing population of enrolled Veterans, including a larger number of women and rural Veterans, VHA is transforming the way it delivers health care. VA estimates it will serve 7.0 million patients in 2017 and 7.1 million in 2018.

Veteran Patient Workload

	2015 Actual	2016 Estimate	2017 Request	2018 Request
Number of Patients	6,741,870	6,874,349	6,993,288	7,104,918
Number of Veterans Enrolled in VA Health care	8,965,923	9,124,712	9,247,803	9,345,912
Number of Inpatient -Treated	890,015	884,954	878,003	871,683
Number of Outpatient Visits	101,604,000	106,759,000	115,119,000	106,824,000

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Department of Veterans Affairs
Medical Care Facilities

	2015 Actual	2016 Estimate	2017 Estimate	2018 Estimate
Veteran Integrated Service Networks (VISNs)	21	21	18	18
VA Hospitals	144	144	144	144
Community Living Centers	135	136	136	138
Residential Rehabilitation Care Facilities	113	116	120	120
VA Medical Center-Based Outpatient Care *	167	168	168	168
Health Care Centers	14	20	20	20
Community-Based Outpatient Clinics	755	763	766	766
Other Outpatient Service Sites	280	268	268	268
Vet Centers	300	300	300	300
Mobile Vet Centers	80	80	80	80

*This category includes all VA Hospitals, plus free-standing Community Living Centers and Residential Rehabilitation Care facilities that also provide outpatient care.

Modeling Health Care Needs

VHA uses the Enrollee Health Care Projection Model (EHCPM), an actuarial model, to support formulation of the majority of the VA health care budget; to conduct strategic and capital planning; and to assess the impact of potential policies and changes in a highly dynamic health care environment.

The EHPCM projects enrollment, utilization, and expenditures for the enrolled Veteran population for 90 categories of health care services 20 years into the future. First, VA uses the Model to determine how many Veterans will be enrolled in VA health care each year and their age, gender, priority, and geographic location. Next, VA uses the Model to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA. Finally, total health care expenditures are developed by multiplying the expected VA utilization by the anticipated cost per service.

The EHPCM takes into account the majority of health care services that have been provided to Veterans, including separate calculations for Long-Term Services and Supports. Activities and programs whose resource levels are not projected by the EHCPCM[10] are called "non-modeled," and can change from year to year. For example, if there are new services that VA is providing to Veterans that were not included in the historical data, those amounts are provided as part of the "non-modeled" request. In other cases, the Administration may alter particular programs from

[10] VA also utilizes the Civilian Health and Medical Program Veterans Administration (CHAMPVA) actuarial model to project costs for the CHAMPVA program for eligible dependents.

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their model-estimated amounts for policy reasons. These two amounts (modeled and non-modeled) make up the total VA Medical Care request.

Change from 2017 Advance Appropriation (AA) and Revised 2017 Request

VA's EHPCM supports over 90 percent of VA's Medical Care request and has been extensively validated. However, health care is an evolving industry, and unknown or unpredictable costs, and growing medical equipment costs, lead VA to request additional funds above the level of funding originally requested to cover these costs. Factors contributing to these additional costs include higher-than-planned participation in the Caregivers program; new costly, but effective, Hepatitis C treatments; increased costs of Long-Term Services and Supports, reflecting trends in the most recent actual data and the continued investment into non-institutional settings; increased facility activation costs as a result of improvements in the construction timeline; and growing medical equipment costs.

The 2017 Budget requests an additional $1.73 billion above the 2017 AA provided in the 2016 enacted appropriation act. The additional costs are attributable to the following:

Veterans Medical Care: Funding Changes for 2017
(Obligations - $ in 000s)

	2017 Advance Appropriation	Revised 2017 Estimate	Difference
Requirements			
Health Care Services Medical Care	56,318,523	56,963,083	644,560
Ending Veterans Homelessness (non add)	*1,393,000*	*1,591,365*	*198,365*
Veterans Choice Act, Section 801	0	853,371	853,371
Veterans Choice Act, Section 802	3,567,467	4,819,819	1,252,352
Veterans Choice Program Cost Shift	-733,000	0	733,000
Long Term Services and Supports	7,875,662	8,587,920	712,258
Other Health Care Programs	2,994,704	2,937,234	-57,470
VA Legislative Proposals	49,390	56,037	6,647
Prior Year Recoveries	736,500	0	-736,500
Total Obligations	**70,809,246**	**74,217,464**	**3,408,218**
Funding Availability			
Advance Appropriation	63,271,000	63,271,000	0
Transfers	-280,675	-282,430	-1,755
Ending Veterans Homelessness (non add)	*1,393,000*	*1,591,365*	*198,365*
Medical Care Collections Fund	3,299,954	3,558,307	258,353
Reimbursements	215,000	184,404	-30,596
Change in Unobligated Balance	0	85,000	85,000
Veterans Choice Act, Section 801	0	853,371	853,371
Veterans Choice Act, Section 802	3,567,467	4,189,819	1,252,352
Prior Year Recoveries	736,500	0	-736,500
Total Funding Availability	70,809,246	72,489,471	1,680,225
Annual Appropriation Adjustment		**1,727,993**	**1,727,993**

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Medical Care Areas of Focus

The 2017 Budget and 2018 AA continue to place emphasis on many different areas critical to the health care of Veterans. There have been many emerging areas of need that VA must respond to. For example, there is an ever-growing population of women Service members leaving the military and coming into the VA's care. There are also a large number of individuals choosing to care for their loved ones through VHA's Caregivers program. The majority of these services are projected by the EHPCM; however, certain programs, such as readjustment counseling, state-based long-term services and support programs, and recently-enacted programs are part of the non-modeled request.

The following table lists modeled and non-modeled Medical Care obligations by program in 2017 and 2018.

2017 Revised Estimate and 2018 Advance Appropriation
Obligations - Model and Non-Model
Includes Veterans Choice Act
(dollars in thousands)

Description	2017 Revised Estimate			2018 Advance Appropriation		
	Model	Non-Model	Total	Model	Non-Model	Total
Health Care Services	$60,946,564	$1,689,709	$62,636,273	$58,975,692	($1,442,799)	$57,532,893
Non-Add Included Above:						
Non Recurring Maintenance	*$0*	*$1,072,985*	*$1,072,985*	*$0*	*$600,000*	*$600,000*
Non Veterans	*$0*	*$400,385*	*$400,385*	*$0*	*$409,021*	*$409,021*
Long-Term Care	$7,251,642	$1,336,278	$8,587,920	$7,664,333	$1,460,132	$9,124,465
Non-Add Included Above:						
State Home Programs	*$0*	*$1,336,278*	*$1,336,278*	*$0*	*$1,460,132*	*$1,460,132*
Other Health Care Programs:						
CHAMPVA	$1,715,000	$115,368	$1,830,368	$1,850,000	$121,700	$1,971,700
Foreign Medical Program (includes Foreign C&P Exams)	$0	$31,280	$31,280	$0	$34,151	$34,151
Spina Bifida Program	$0	$58,026	$58,026	$0	$57,601	$57,601
Children of Women Vietnam Veterans	$0	$200	$200	$0	$200	$200
Caregivers (Title 1)	$0	$724,628	$724,628	$0	$839,828	$839,828
Indian Health Service (PL 111-148)	$0	$28,062	$28,062	$0	$29,358	$29,358
Camp Lejeune - Veterans	$11,347	$0	$11,347	$11,794	$0	$11,794
Camp Lejeune - Family	$0	$9,840	$9,840	$0	$8,050	$8,050
Readjustment Counseling	$0	$243,483	$243,483	$0	$243,483	$243,483
VA Legislative Proposals	$0	$56,037	$56,037	$0	$57,997	$57,997
Obligations [Grand Total]	$69,924,553	$4,292,911	$74,217,464	$68,501,819	$1,409,701	$69,911,520

The following table outlines some of the key areas of VA care and descriptions of these major programs. These are but a few of the critical areas that VHA works in; others include special work for the military personnel who served in the Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), Operation New Dawn (OND) , and Operation Inherent Resolve (OIR) conflicts, and treatment of traumatic brain injuries and spinal cord injuries.

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Veteran Medical Care: Key Focus Areas
(Obligations - $ in millions)

	2015 Actual	2016 Estimate	2017 Request	2018 Request
Caregivers	454	622	725	840
Hepatitis C (New Drug Treatments)	1,218	1,500	1,500	600
Women Veterans (Gender-Specific Care)	439	475	515	557
Mental Health	6,851	7,484	7,832	7,997
Telehealth	1,051	1,114	1,171	1,226
Rural Health Initiative	219	270	250	250
Homeless Programs	1,507	1,477	1,591	1,122
Activations	558	598	836	498

Caregivers. VHA provides support to those individuals that act as a Caregiver for a Veteran. There are several support and service options for the Caregiver. For example, the Caregiver Support Line – 1-855-260-3274 – is available to: respond to inquiries about Caregiver services, as well as serve as a resource and referral center for Caregivers, Veterans and others seeking Caregiver information; provide referrals to local VA Medical Center Caregiver Support Coordinators and VA/community resources; and provide emotional support.

The Program of Comprehensive Assistance for Family Caregivers, established in PL 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, has allowed VA to provide additional supports and services to Caregivers of eligible Veterans injured in the line of duty on or after September 11, 2001. Eligible Veterans include those who sustained a serious injury – including traumatic brain injury, psychological trauma, or other mental disorder – incurred or aggravated in the line of duty, on or after September 11, 2001. Services for this group of Caregivers include: monthly stipend travel expenses (including lodging and per diem while accompanying Veterans undergoing care); access to health care insurance (if the Caregiver is not already entitled to care or services under a health care plan); mental health services and counseling; and Caregiver training. In 2015, 24,771 Primary Family Caregivers were approved for the program with 5,772 Primary Family Caregivers who did not previously have insurance receiving coverage under VA's Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The 2017 Budget requests $725 million for the Caregivers program to support over 36,644 Caregivers, up from about 30,644 in 2016. Funding requirements for Caregivers are driven by an increase in the eligible Veteran population, with Caregiver enrollment increasing by an average of about 400 each month.

Hepatitis C. In 2014, VA began a ground-breaking system of care for Veterans with the Hepatitis C Virus (HCV). The Food and Drug Administration approved two new, highly-effective drugs – Sofosbuvir and Simeprevir – that will change the lives of Veterans infected with Hepatitis C. Prior to the introduction of the new high-cost treatment therapies in the VA system in January 2014, the treatments for Hepatitis C were often ineffective and presented considerable side effects. By contrast, the new treatment options are considerably more effective at curing patients with HCV, present significantly fewer side effects than earlier options, and are much simpler to administer. Cure of HCV significantly decreases the risk of progression of the

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disease to cirrhosis, liver failure, liver cancer, and death. VA wants to ensure that all Veterans who are eligible for the new drugs, based on their clinician's recommendation, receive the medication. As happens with new medical advances, the new drugs are expensive even though VA has successfully worked with the manufacturers to receive the best price possible. VA estimates the drugs will cost $1.5 billion in 2016 and $1.5 billion in 2017, providing over 29,700 treatments in 2016 and over 35,000 treatments in 2017.

Women Veterans. In 2015, Women Veterans comprised nearly 15 percent of active duty military forces and 19 percent of National Guard and Reserves. The growing number of Women Veterans means that VA must provide services and infrastructure suited to gender-specific needs. Some of these services include maternity and gynecology care as well as ensuring privacy and consideration of gender-specific conditions and disorders. VA is anticipating and preparing not only for the increase in the number of women Veterans but also for the accompanying complexity and longevity of their treatment needs. Security and privacy for women Veterans is a high priority for VA. VA is training providers and other clinical staff, enhancing facilities to meet the needs of women Veterans, and reaching out to inform women Veterans about VA services. VA is redesigning women's health care delivery with models of care that ensure women receive equitable, timely, high-quality primary health care from a single primary care provider and team, thereby decreasing fragmentation and improving quality of care for women Veterans. The 2017 Budget requests $515 million for gender-specific Women Veterans' health care, an increase of 8.5 percent above the 2016 level.

Mental Health. Mental health services available to Veterans range from treatment of a variety of common mental health conditions in primary care to more intensive interventions in specialty mental health programs for more severe and persisting mental health conditions. In 2015, with resources totaling $6.9 billion, VA provided specialized mental health treatment to more than 1.4 million Veterans and completed hiring initiatives that increased the mental health workforce by more than 1,600 new clinical providers and over 960 Peer Specialists and Peer Support Apprentices. VHA dedicates all the resources necessary to provide care for Veterans with a broad range of conditions such as depression, anxiety, Post-Traumatic Stress Disorder (PTSD), and psychosis. VA provides services through several means, such as: mental health professionals embedded in Patient Aligned Care Teams (PACTs) to help assessment of patients along with primary care doctors and medical staff; intensive recovery-oriented individual and group treatments; and inpatient care for the most serious cases of suicidal or homicidal patients or patients with acute psychosis. VA also specializes in care for Veterans suffering from PTSD and substance use disorders and mental health services for Women and older Veterans. In addition to a great expansion in the available of on-line information, Veterans can call the Crisis Line when any type of help is needed – 1-800-273-8255. The 2017 Budget requests $7.8 billion for Veterans mental health services, an increase of 4.6 percent above the 2016 level.

Telehealth. Telehealth delivers health care services remotely to patients and VA is using virtual care more frequently to reach rural Veterans. In 2015, with resources totaling $1.05 billion, VHA Telehealth Services provided more than 2 million consultations to over 677,000 Veterans, 45 percent of whom were in rural areas. In 2017, VA expects to deliver telehealth-based services to nearly 762,000 Veterans. Telehealth improves access to care by increasing the ways Veterans can receive medical advice, reducing the time and cost to travel to receive care, and increasing

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the probability that Veterans in a remote location can receive care. Some examples of telehealth include: Tele-Intensive Care, TeleAudiology, TelePathology, Teleradiology and TeleMental Health. The 2017 Budget requests $1.2 billion for Telehealth, an increase of 5.1 percent above the 2016 level.

Rural Health. As a complement to telehealth, VA is committed to improving the care and access for Veterans in geographically rural areas. Projects funded through the VHA Office of Rural Health (ORH) include home-based primary care, training and education of medical residents in rural clinical setting, equipment for rural Community Based Outpatient Clinics (CBOCs), transportation of rural Veterans, and home-based therapies. Through these and other rural health initiatives, ORH has addressed the unique needs of over three million enrolled Veterans living in rural and highly rural areas, which make up approximately 33 percent of all Veteran enrollees. The 2017 Budget requests $250 million for rural health projects.

Homeless Programs. VHA continues to work with its interagency partners to end Veteran homelessness. This multi-year program has seen great success – reducing Veterans' homeless from 74,770 in 2010 to less than 48,000 as of the last official "Point in Time" Count in January 2015. This is over a 36 percent decline in five years. In 2015, over 64,902 homeless or at-risk Veterans (including formerly homeless Veterans) accessed services and nearly 36,000 Veterans and their family members were prevented from becoming homeless. In 2017, VA will continue to focus on prevention and treatment services. This involves providing a comprehensive continuum of care that addresses the psychosocial factors surrounding homelessness while building the capacity of available residential, rehabilitative, transitional, and permanent housing supply. VHA continues to work closely with the Department of Housing and Urban Development and other Federal and State agencies, VSOs, national advocacy groups, and community-based providers. The request for 2017 of $1.6 billion is based on a comprehensive analysis that provided VA with the information on what type of resources is most needed and where they are needed across the country.

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Medical Community Care

Budget Authority - $ in 000s

	2015 Enacted	2016 Estimate	2017 Request	2018 Request
Medical Service Transfer			7,246,181	
Advance Appropriation				9,409,118
Veterans Choice Funding (Section 802)			4,661,378	
Medical Care Collections Fund			250,000	250,000
TOTAL			**12,152,559**	**9,659,118**

In 2017, VA plans to spend $12.2 billion from various sources to support medical care for Veterans delivered in non-VA settings (called Care in the Community). VA is seeking authority to transfer funds from existing accounts for the initial funding of this account in 2017, with Advance Appropriation requested for 2018. In 2015, VA paid $10.5 billion for this type of Care in the Community.

Description:
VA is proposing creation of a new Medical Community Care appropriations account to consolidate all community care programs under a single appropriation for both Veterans and other beneficiaries. This appropriation supports non-VA Hospital Care and Medical Services to eligible Veterans through contracts or agreements with certain eligible entities, as well as pays for care for other eligible beneficiaries.

VA believes that using one fund for all community care aligns with VA's vision for the future of health care delivery, which aims to provide Veterans and beneficiaries the best care wherever they seek it, both inside and outside VA. This new account will provide transparency and clear funding accountability for care delivered in the community for Veterans and eligible dependents. It would enable VA to streamline the authorization process to deliver care to Veterans. In addition, the Budget requests authority to receive advance appropriations for the Medical Care Community account and to deposit medical care collections in the account.

In addition to the new account for Medical Community Care, VA will pursue legislative and management improvements that will provide a simplified program that is easy to understand and administer and that meets the needs of Veterans, employees, and community providers. These improvements include delivering personalized, proactive, and patient-driven health care; using metrics and data analytics to drive improvement; using innovative technologies and care models to optimize health outcomes; and maintaining a high-performing network to deliver Care in the Community.

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Veterans Health Administration
Medical and Prosthetic Research

Budget Authority
($ in 000s)

	2015 Actual	2016 Estimate	2017 Request
Research Appropriation	588,513	630,735	663,366
Medical Care Support	519,393	536,125	563,861
Federal and Non-Federal Resources	563,384	685,000	685,000
Reimbursements	32,751	40,000	40,000
TOTAL	**1,704,041**	**1,891,860**	**1,952,227**

FTE

FTE	2015 Actual	2016 Estimate	2017 Request
TOTAL	**3,521**	**3,551**	**3,606**

To provide Veterans with the best technological and medical solutions to their health care needs, VA's robust team of researchers continuously strives to find breakthroughs that will materially improve the lives of Veterans and others. The VA Research and Development (R&D) program plays a key role in advancing the health and care of Veterans and is uniquely positioned to continue to lead a national transformation of American health care. The 2017 Budget requests an appropriation of $663.4 million for Medical Research, an increase of $32.6 million (5.2 percent) above the 2016 appropriation of $630.7 million.

Because more than 60 percent of VA researchers are also clinicians who take care of patients, VA is uniquely positioned to move scientific discovery from investigators' laboratories to patients' care. The VA research program plays a critical role in attracting and retaining top-quality physicians in VA. A program evaluation conducted by Abt Associates found that 79 percent of VA clinicians cited the research program as a factor in coming to VA, while over 90 percent cited it as a reason for staying.

The VA Office of Research and Development (ORD) consists of four main research services that together address the full spectrum of Veterans' health needs. The four services are: Biomedical Laboratory; Clinical Science; Health Services; and Rehabilitation.

VA works to support the needs of Veterans returning from deployment as well as in the later years of their lives. VA will support a wide array of research and development in engineering and technology to improve the lives of Veterans with disabilities. Work includes both prosthetic systems that replace lost limbs and those that activate residual or paralyzed nerves, muscles, and limbs. A comprehensive research program supports VA's commitment to the health and care of the increasing number of Veterans. Recent areas of inquiry include the Million Veteran Program (MVP), a groundbreaking genomic research program, seeks to collect samples and general health information from one million Veterans. MVP will use genetic analysis to show how to improve treatments by understanding individual patients, thus improving care for Veterans and the

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Nation. Research to benefit Gulf War Veterans will also remain a priority for VA in 2017. VA supports a range of studies on post-deployment mental health concerns such as PTSD, depression, anxiety, substance abuse, and suicide. These are but a few of the areas that VA will be engaged in over 2017. Other areas include work on chronic diseases, reproductive health, and preventative care to ensure continued high-quality care for Veterans as they age. VA will build on these studies to advance the President's Precision Medicine initiative in 2017 and 2018. VA Research works to identify and evaluate innovative strategies that can improve access and quality, especially for those Veterans' that may face barriers to such care, for example, rural Veterans.

In 2017, VA is prioritizing its research portfolio towards precision medicine, including a substantial $50 million investment in genomic sequencing on Veterans enrolled in MVP. This genomic sequencing initiative is not a project, per se, and as a result it is not reflected in the following Designated Research Areas (DRAs) table. Thus, most DRAs show a minor decrease from 2016 levels, as some additional program resources are directed towards precision medicine. Projected spending and number of projects for every DRA are above 2015 levels.

The VA cancer research portfolio has one of the largest investments in resources, with close to 250 active projects and $59.5 million allocated in 2017, and is targeted towards understanding and preventing cancers prevalent in the Veteran population. Topics being investigated in the portfolio range from the basic biology and genetic underpinning in laboratory based research to large definitive clinical trials of treatments and approaches to advance care. Discoveries improve Veterans' lives as well as the general population.

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The following table details the major focus areas of Medical Research in 2017. DRAs represent areas of particular importance to our Veteran patient population. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation and accurately reflect amounts by DRAs.

Appropriations by Designated Research Areas
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Request	2016-2017 Inc/Dec
Acute & Traumatic Injury	$20,298	$21,313	$21,313	$21,313	$0
Aging	$146,856	$154,199	$154,199	$150,344	($3,855)
Autoimmune, Allergic & Hematopoietic Disorders	$27,699	$29,084	$29,084	$28,357	($727)
Cancer	$52,120	$57,783	$57,783	$59,500	$1,717
CNS Injury & Associated Disorders	$89,041	$93,493	$93,493	$91,156	($2,337)
Degenerative Diseases of Bones & Joints	$30,242	$31,754	$31,754	$30,960	($794)
Dementia & Neuronal Degeneration	$24,838	$26,080	$26,080	$25,428	($652)
Diabetes & Major Complications	$35,009	$36,759	$36,759	$35,840	($919)
Digestive Diseases	$20,680	$21,714	$21,714	$21,171	($543)
Emerging Pathogens/Bio-Terrorism	$959	$1,007	$1,007	$982	($25)
Gulf War Veterans Illness	$10,500	$15,000	$12,500	$12,188	($313)
Health Systems	$62,467	$72,667	$72,667	$70,850	($1,817)
Heart Disease/Cardiovascular Health	$62,322	$65,438	$65,438	$63,802	($1,636)
Infectious Diseases	$33,042	$34,694	$34,694	$33,827	($867)
Kidney Disorders	$20,914	$21,960	$21,960	$21,411	($549)
Lung Disorders	$26,990	$28,340	$28,340	$27,632	($709)
Mental Illness	$110,310	$115,826	$115,826	$115,826	$0
Military Occupations & Environ. Exposures	$14,045	$16,633	$16,633	$16,217	($416)
Other Chronic Diseases	$4,883	$5,127	$5,127	$4,999	($128)
Prosthetics	$15,075	$15,829	$15,829	$15,433	($396)
Sensory Loss	$17,085	$17,939	$17,939	$17,491	($448)
Special Populations	$19,588	$20,567	$20,567	$20,053	($514)
Substance Abuse	$29,405	$30,875	$30,875	$30,103	($772)

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Veterans Benefits Administration

Budget Authority
($ in thousands)

	2015 Actuals	2016 Estimate	2017 Request
Compensation and Pensions	$79,071,000	$76,865,545	$86,083,128
Readjustment Benefits	$14,997,136	$14,313,357	$16,340,828
Vocational Rehabilitation Loan Program*	$481	$477	$425
Post-Vietnam Era Veterans' Education Account	$0	$0	$0
Veterans Housing Program*	$849,993	$841,319	$571,981
Native American Veterans Housing Loan Program*	$2,222	$1,807	$1,163
Insurance Benefits	$63,257	$77,160	$108,525
VA Wide Offsets	$439,996	$296,765	$525,109
Subtotal, Mandatory**	**$95,424,085**	**$92,396,430**	**$103,631,159**
Discretionary – General Operating Expenses	$2,531,899	$2,707,734	$2,826,160
Total	**$97,955,984**	**$95,104,164**	**$106,457,319**

*2015 and 2016 include upward re-estimates. The 2017 request does not include any re-estimates, which are calculated at the end of the fiscal year.
**Includes credit reform administration costs but does not reflect scoring impacts of mandatory trust funds, proprietary receipts, or intragovernmental transactions.

The 2017 Budget requests $2.83 billion for VBA General Operating Expenses (GOE), an increase of $118.4 million (4.4 percent) above the 2016 enacted level. The request will support 22,171 FTE, an increase of 300 FTE above 2016.

FTE

FTE	2015 Actual	2016 Estimate	2017 Request
Discretionary – General Operating Expenses	21,522	21,871	22,171

VBA has been successfully reaching more and more beneficiaries though the administration of claims processing and other activities. VBA has been working to reduce the time any Veteran needs to wait to get a claim adjudicated and ensure when that occurs that it is done fairly and correctly. The following chart shows the historical and projected growth across the VBA's primary lines of business.

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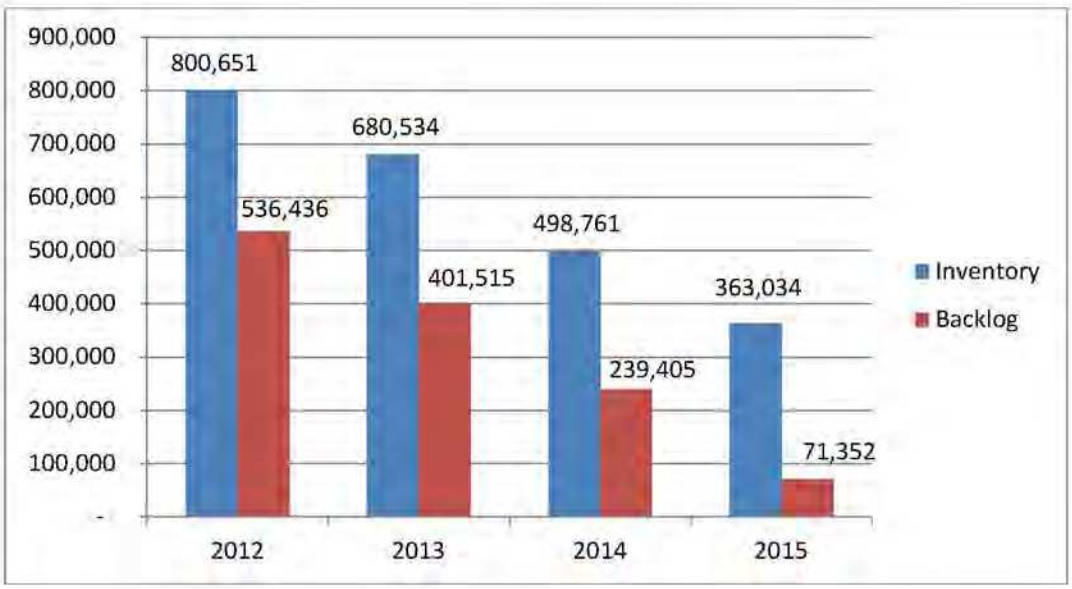
Number of Beneficiaries

	2015 Actual	2016 Estimate	2017 Request
Compensation Beneficiaries	4,449,448	4,641,415	4,833,379
Pensions Beneficiaries	506,307	503,390	506,699
Education Program Trainees	1,019,191	1,063,110	1,082,328
Vocational Rehabilitation and Employment Beneficiaries	131,647	135,120	140,704
New Housing Loans	614,514	541,865	429,079
Insured Persons	6,473,869	6,553,040	6,479,349

Disability Compensation Claims Backlog

Due to VBA's aggressive efforts toward bringing down the backlog, VBA completed a record-breaking 1.39 million claims in 2015 and reduced the claims backlog by 88 percent from a peak of 611,000 claims in March 2013 to 75,480 on December 31, 2015. This means that VBA has reduced the number of Veterans waiting longer than 125 days for claims decisions by 88 percent, and, in 2015, Veterans waited, on average, 189 fewer days for a claim decision than Veterans in 2013. In 2016, VBA will continue its efforts to eliminate the backlog.

Department of Veterans Affairs
Disability Claims Inventory and Backlog
(End of Year)



Payments to Veterans and Beneficiaries

The amount of benefits payments is increasing year over year, and 2017 is expected to follow this trend. This is a result of the success of adjudicating claims faster.

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Veterans Benefits: Claims Payments
($ in 000s)

	2015 Actuals	2016 Estimate	2017 Request
Compensation	$70,332,409	$75,340,540	$79,677,123
Pensions	$5,496,232	$5,738,802	$6,087,586
Education Benefits	$12,626,793	$13,699,309	$14,385,080
Vocational Rehabilitation and Employment	$1,143,656	$1,354,665	$1,447,263
Total	**$89,599,090**	**$96,133,316**	**$101,597,052**

Claims Quality

Just as important as the number of claims processed is the quality of the claim adjudication. In addition to increased production, claims processing accuracy improved from 84 percent in June 2011 to 90 percent in 2015. When measuring accuracy at the issue level within a claim, accuracy is now at 96 percent. VA is reviewing its claims processing accuracy metrics and goals to ensure that VA continues to drive decisions of the highest quality. VA plans to engage its VSO partners and other stakeholders as more information becomes available.

Additional Investments in 2017

Personnel. While overtime has proven to be a successful surge strategy to meet the goal of reducing the backlog, it is unsustainable as a long-term performance management solution. In addition, with the increased processing of disability claims, there has been a downstream effect on non-rating claims and appeals work. Therefore, VA is seeking increased staff – primarily to meet the needs of other benefits areas that have not been highlighted as VA has worked to bring the disability claims backlog down.

To ensure all aspects of the claims process is improved for Veterans, VA is requesting funding to hire additional claims processors to address these specific workload increases. VA is requesting $54 million to fund 300 non-rating claims processors and fund critical claims processing support activities. With the additional employees, VA will realize improved non-rating workload completed to current timeliness standards and provide flexibility for addressing appeals and rating workload.

National Work Queue (NWQ). VBA distributes claims electronically from a centralized queue to Regional Offices (RO) that have additional capacity using the electronic NWQ, a national workload management strategy. With all claims placed in the electronic NWQ, Veterans' claims will be automatically directed across all ROs to efficiently match claim demand with available expertise and processing capacity regardless of RO jurisdiction, delivering benefits to Veterans more quickly and accurately. In 2017, VA is requesting $3.3 million to provide the requisite funding to resource and support 13 employees to manage the NWQ across the VBA enterprise.

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Centralized Mail. Centralized mail consolidates inbound paper mail from VBA's ROs to a centralized intake site. This initiative expands VBA's capabilities for scanning and conversion of claims evidence, increases electronic processing capabilities, and assists in converting 100 percent of received source materials to an electronic format. In 2015, VBA completed deployment of centralized inbound mail all 14 ROs. The 2017 budget request of $26.7 million provides resources to sustain operations at all ROs and positions VBA to expand centralized mail operations to other lines of business and centralize outbound correspondence to Veterans.

VBA Transformation

Along with the new investments in 2017, VBA is continuing the largest transformation in its history, creating a Veteran-centric service organization in which VBA engages Service members from the time they enter service, throughout life, to the final tribute when their service is memorialized. VBA is adapting to new realities, leveraging new technologies, and better serving a changing population of Veterans with renewed commitment. This will ensure a total lifelong engagement with Service members, Veterans, their families, and Survivors. VBA's transformation includes people, process, and technology initiatives to transform the way benefits and services are delivered to Veterans, their families, and Survivors for generations to come. VBA will foster technological innovations that increase Veteran access to information and continue to evolve its electronic claims processing environment to provide first-rate and timely benefits to beneficiaries with greater efficiency.

People. VBA employees – over 50 percent of whom are Veterans – are leading advocates for Veterans, Service members, their families, and Survivors. VBA provides customized, modular training to strengthen the expertise of its workforce and increase proficiency while emphasizing accountability, quality, and productivity through new national training programs and standards. VBA's people initiatives improve how the staff is organized and trained and include, but are not limited to, intake processing centers, segmented lanes, cross-functional teams, Challenge training, skills certification, and Quality Review Teams (QRTs).

Processes. VBA's process initiatives streamline business processes and create efficiencies in claims processing. Process initiatives include, but are not limited to Fully Developed Claims (FDC), Disability Benefits Questionnaires (DBQs), Rules-based Calculators, Rules-Based Processing System, Appeals Design Team Simplified Notification Letters, Rater Decision Support Tools, and Gold Standard Service Treatment Records. VBA uses "design teams" to support business-process transformation. Using design teams, VBA conducts rapid development and testing of process changes, automated processing tools, and innovative workplace incentive programs. The goal of a design team is to implement, execute, and measure an improved facet of our organizational model with a mindset toward increasing the productivity of employees and greater transparency for Veterans regarding their claim status.

Technology. A digital and electronic operating environment allows greater exchange of information and increased transparency to VBA's clients, workforce, and partners. Increased use of state-of-the-art technology plays a major role in enabling VBA to redirect capacity to better serve Veterans and their families. As explained by the examples below, VBA's technology initiatives are key elements of VBA's business operating model and include, but are not limited

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to VBMS; Veterans Experience Office (VEO); Veterans Claims Intake Program (VCIP); Post-9/11 GI Bill automated processing, and Virtual Lifetime Electronic Record. VBA's strategy includes active stakeholder participation and Veterans Service Organizations (VSOs), State Departments of Veterans Affairs, County Veterans Service Officers, and DoD) to provide electronic files and FDCs submitted on-line using the filing application in eBenefits and the Stakeholder Enterprise Portal (SEP). VBA continues to aggressively promote the value of eBenefits and the ease of enrolling Veterans who want to engage VA on-line at the time of their choosing.

Technology Investments

Veterans Benefits Management System (VBMS). VBMS, as VBA's key business transformation initiative, provides a paperless claims-processing environment and improved business processes to provide Veterans and their dependents with timely, high-quality decisions. National deployment of VBMS was completed in June 2013 and provides access to over 28,000 end users. VBMS allows VBA to centrally manage the claims workload at the national level and direct cases electronically across its network of ROs to more efficiently match claims demand with available processing capacity. As of 2015, 99.8 percent of VA's disability claims inventory was processed electronically. VBA will invest $37.4 million from base resources to allow VBMS to assist VA in going beyond eliminating the existing claims backlog by providing additional system capabilities to support the integrated claims processing solutions identified in the VA 2014-2020 Strategic Plan.

Veterans Claims Intake Program (VCIP). VCIP streamlines processes for receiving digital records and data into VBMS and other VBA systems, transitioning VBA from a paper-based claims environment to a digital operating environment. It scans paper claims, converts them into digital format, and extracts important data for input into electronic folders. By the end of 2017, VCIP will have converted and uploaded more than 2.5 billion images from paper since July 2012. In addition to supporting scanning operations for incoming claims, VBA will invest $142.9 million to allow the digital intake of military, income, medical, and employment records from other federal agencies and private providers to be expanded from 2016. This will broaden electronic evidence exchange for processing all types of claims more accurately and more rapidly by building additional interfaces for Official Military Personnel Folders (OMPF) from DoD and interfaces with health networks, hospitals, and private clinicians.

Veterans Experience Office (VEO) (previously Veterans Relationship Management (VRM)). The VEO initiative will continue its work to help facilitate an increasingly more Veteran-centric digital operating environment. VEO will deliver a scalable, enterprise-wide, services-based technology environment that will be the foundation for how Veterans are served and how benefits and services are delivered. This new model will provide VA an integrated services delivery platform with the approach of placing the Veteran at the center of the service with all business requirements and design being driven from the Veteran perspective. VBA's will invest $14 million in 2017 to support ongoing operations and continued efforts to pilot and deploy new solutions for VBA mobile applications that expand access to self-service tools and benefits/services information in VBA portal environments; develop new service features in the

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Stakeholder Enterprise Portal for medical providers, loan officers, fiduciaries, and funeral directors; and integrate VetSuccess with Career Center for Veterans enabling to search for jobs posted by unique employers targeting Veterans.

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National Cemetery Administration

Budget Authority
($ in 000s)

	2015 Enacted	2016 Estimate	2017 Request
Operations and Maintenance	256,630	271,220	286,193
Major Construction	10,000	155,764	137,000
Minor Construction	51,212	69,050	56,890
Grants for Construction of Veterans Cemeteries	46,000	46,000	45,000
Facilities Operation Fund *	104	90	90
National Cemetery Gift Fund *	117	160	160
Compensation and Pensions: (Headstones and Markers; Graveliners; Outer Burial Receptacles; Caskets and Urns)	80,743	94,921	94,547
TOTAL	**444,806**	**637,205**	**619,880**

* Facilities Operation Fund and Gift Fund are not appropriated funds

The 2017 Budget requests $286.2 million for NCA operations, an increase of $15 million (5.5 percent) over 2016. The Budget will support 1,809 FTE for NCA.

FTE

	2015 Actual	2016 Estimate	2017 Request
Operations and Maintenance Appropriation	**1,730**	**1,789**	**1,809**
TOTAL	**1,730**	**1,789**	**1,809**

VA honors Veterans and their family members with final resting places in National shrines with lasting tributes that commemorate their service and sacrifice to our Nation. Fulfilling its mission, NCA interred 130,424 Veterans and eligible family members in 2015. In 2017, NCA will provide perpetual care for the following assets:

NCA Assets in 2017

National Cemeteries	Soldiers' Lots and Monument Sites
134	33

Veteran and Eligible Family Burials Provided

	2015 Actual	2016 Estimate	2017 Request
Interments	**130,424**	**132,622**	**132,093**

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Highlights of the 2017 Request for NCA

Discretionary Funds

- 49.0 percent of the total National Cemetery Administration's (NCA) budget is for the operation and maintenance of VA's national cemeteries.
- 27.1 percent of the NCA budget is for the construction and renovation of VA's national cemeteries and facilities.
- 7.7 percent of the total resources under NCA are available for grants to states and tribal organizations for Veterans cemeteries.

Mandatory Funds

- 3.2 percent of the total funding is available for Graveliners, Outer Burial Receptacles (OBRs), Caskets and Urns.
- 13.0 percent of the total is for Headstones and Markers

Accomplishments

- As a result of the recent expansion and the opening of new state Veterans cemeteries, the percentage of Veterans served by a burial option within 75 miles of their residence has increased steadily from 83.4 percent in 2007 to 89.8 percent in 2015. In 2017, the percentage is expected to increase to 91.8 percent.

- VA introduced new burial policies in the 2011 Budget that will result in the opening of five new national cemeteries that will provide an additional 550,000 Veterans access to a burial option. As a result, VA is in the process of designing and constructing three out of the five new cemeteries and is beginning design of the remaining two. VA will also improve access through the construction of columbarium-only satellite cemeteries in densely populated urban areas and establish a national cemetery presence in rural areas where the Veteran population is less than 25,000 within a 75-mile service area. VA has established one rural cemetery and is in the process of acquiring land for seven additional sites.

Expected Results

The 2017 Budget request will support the following results:

- NCA will increase its service level to provide 91.8 percent of America's Veterans with a burial option within 75 miles of their residence
- 97 percent surveyed will rate the quality of service of NCA as excellent.
- 95 percent of graves in national cemeteries will be marked within 60 days of interment.
- 80 percent of applications for headstones and markers will be processed within 20 days for the graves of Veterans who are not buried in national cemeteries.
- 99 percent surveyed will rate national cemetery appearance as excellent.

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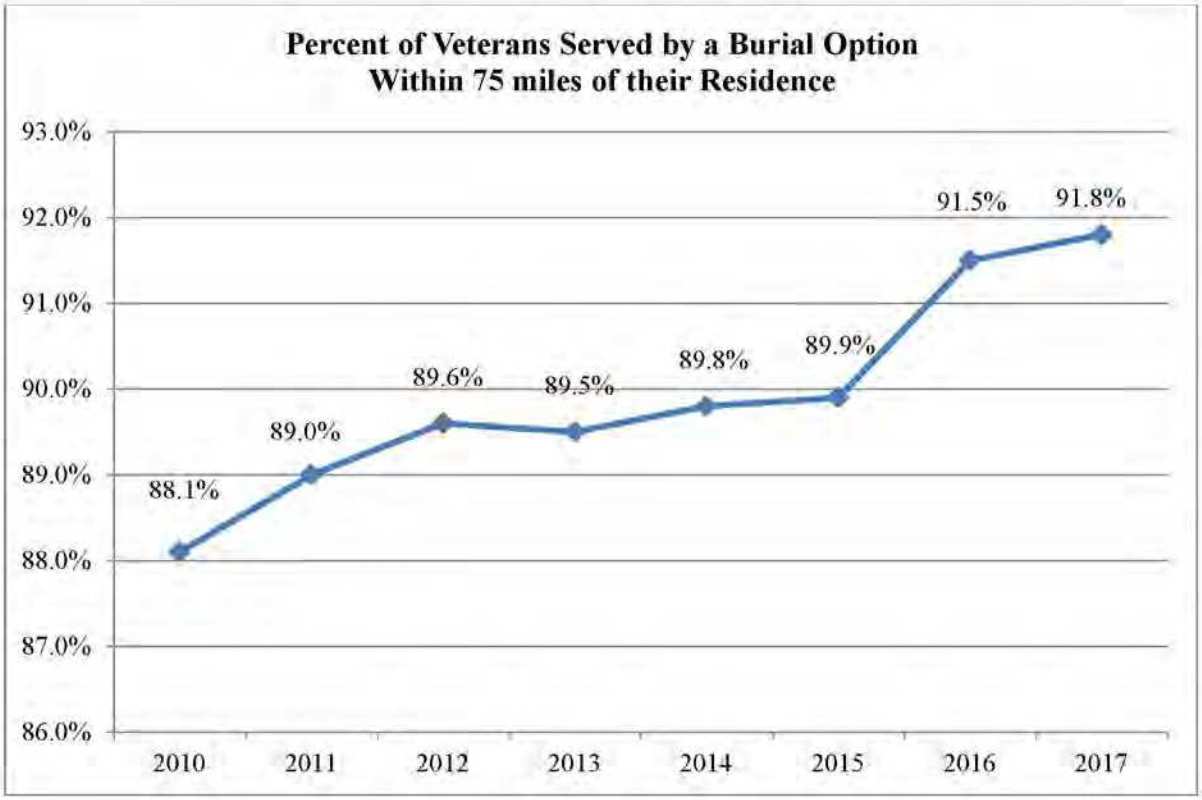

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Board of Veterans' Appeals

Budget Authority

($ in 000s)

	2015 Enacted	2016 Estimate	2017 Request
BVA Budget Authority	**99,180**	**109,884**	**156,096**

FTE

	2015 Actual	2016 Estimate	2017 Request
BVA FTE	**646**	**680**	**922**

Mission

The Board of Veterans' Appeals (Board) is the component of the Department of Veterans Affairs (VA) responsible for making final decisions on behalf of the Secretary for the thousands of claims for Veterans' benefits that are presented to the Board for appellate review. Despite the dynamic environment in which the Board has operated since the advent of judicial review, the mission has remained relatively unchanged. The Board conducts hearings and issues decisions for Veterans and other appellants in compliance with the requirements of law.

The Need for Reform

The present legal framework for the VA appeals process is complex, inefficient, and confusing, and Veterans are waiting too long for final resolution of an appeal. For those appeals that reached the Board, on average, Veterans were waiting at least five years for an appeals decision, with thousands of Veterans waiting much longer. The status quo isn't acceptable for Veterans or for tax payers.

The increase in Veterans filing appeals is a function of the number of claims decisions made throughout VA. As VA has increased claims decision output over the past 5 years, appeals volume has proportionately grown.

In 2015, the Board served 55,713 Veterans, surpassing the 2014 number of Veterans served. The Board set this new all-time high while maintaining a quality rate of 93.98 percent, exceeding the Board's longstanding goal of 92 percent. The Board also conducted 12,738 hearings with Veterans, which represents a 17 percent increase over the number of hearings conducted in 2014. However, despite the Board's increased productivity, pending inventory is expected to increase due to increases in incoming workload and an appeals system that is encumbered by antiquated laws that do not serve Veterans well.

Without fundamental legislative reform and additional resources, VA projects that the number of pending appeals will soar to more than 2.2 million by the end of 2027. Absent significant reform, this workload would require significant resources but would not generate improvements

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in the time Veterans wait for appeals decisions. The appeals process must be modernized to put the needs, expectations, and interests of Veterans first.

Simplified Appeals Process

The 2017 Budget proposes a Simplified Appeals Process – legislation, resources, and technology – that will provide Veterans with a straightforward, fair, and streamlined appeals process in which they will receive a final decision within 365 days from filing an appeal by 2021. Under Simplified Appeals all Veterans' rights are preserved. If a Veteran disagrees with any or all of the appeals decision, he or she will always have the option of filing a new claim for the same benefit once the appeal is resolved.

In 2017, the Budget requests $156.1 million and 922 FTE for BVA, an increase of $46.2 million and 242 FTE above the 2016 enacted level. This request represents the initial implementation of a long-term sustainable plan to provide the best services to Veterans and best policy option to taxpayers. Without legislative reform, VA will need to continue to make substantial resource investments in the current, inefficient process set forth in law.

In order to address the current legacy appeals in the system, the Board will require FTE increases in the short term to resolve the nearly 440,000 pending appeals. However, by 2022, VA would be able to reduce appeals FTE to a sustainment level that is less than the current level and, Department-wide, about 4,000 fewer FTE than would be required to address this workload with FTE resources alone.

Below are several charts that show the transition to a simplified appeals system and impact of reform on inventory and costs.

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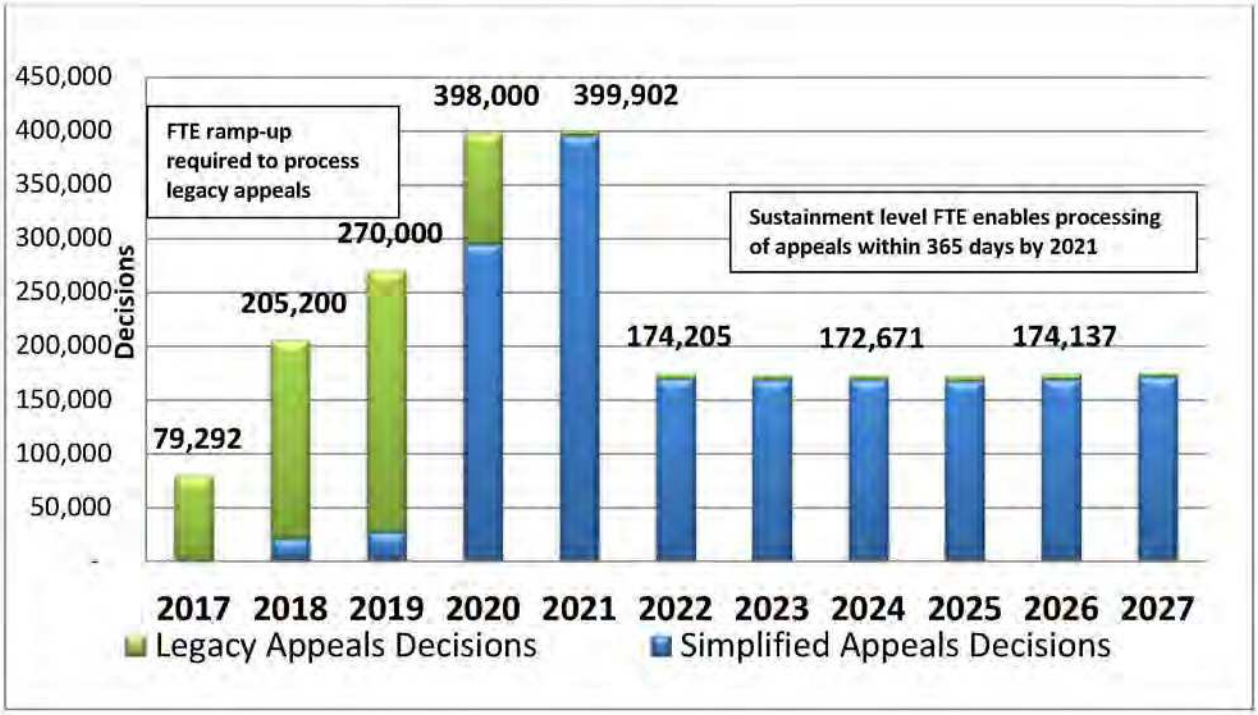
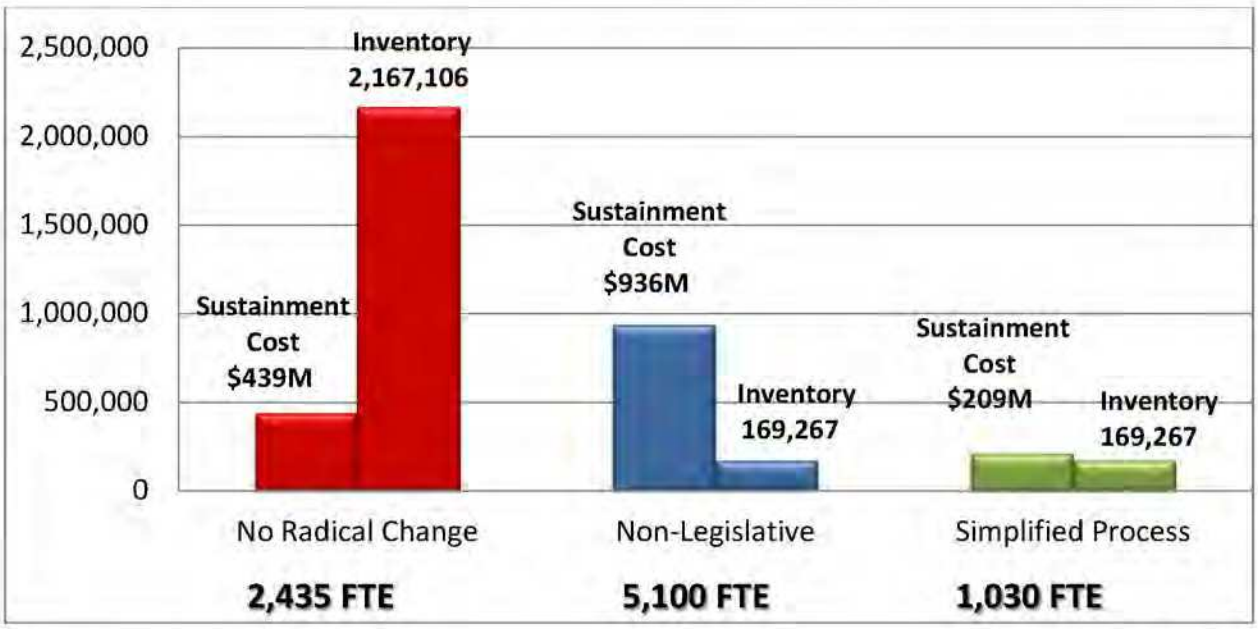
Department of Veterans Affairs
Transition to a Simplified Appeals Process:
Ramp-Up and Long-Term Sustainment



Simplified Appeals Initiative
Impact on BVA Inventory and Annual Sustainment Costs by 2027



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Office of Information and Technology

Budget Authority
($ in 000s)

	2015 Enacted	2016 Estimate	2017 Request
Development	548,127	504,743	471,269
Sustainment	2,316,217	2,512,863	2,534,442
Pay and Administration	1,039,000	1,115,757	1,272,548
TOTAL	**3,903,344**	**4,133,363**	**4,278,259**

FTE

	2015 Actual	2016 Estimate	2017 Request
TOTAL	**7,309**	**7,7631**	**8,334 1/**

Note: FTE includes Veterans Choice Act personnel.
1/ Includes realignment of 599 FTE

Information technology is critical to VA's success. A continued increase in investment in IT development and support is essential for VA to continue to deliver medical care and benefits to Veterans. VA needs to modernize the electronic health records of Veterans, deploy state-of-the-art technology for medical staff in rural communities, and support electronic benefits claims processing, to name a few critical areas. In 2017, VA is proposing to transfer 599 staff (FTE) from the VA Enterprise Operations Franchise Fund (EOFF) to the Office of Information Technology (OIT). The EOFF has been responsible for centralized computer center operations and is better aligned under OIT. The funding for this portion of the Franchise Fund was already fully funded under the IT appropriation and therefore the impact of the realignment is budget neutral.

Accomplishments

In 2015, VA's Office of Information and Technology had many successes:

- VBMS conducted 14 software releases (three major and 11 minor releases, and software patches) and on-boarded five new stakeholders. VBMS conducted 13 requirements rotations (resulting in over 380 requirements artifacts) and 12 design sessions. During the 14 weeks of User Acceptance Testing (UAT), VBMS executed 1,991 test runs.

- The National Telehealth programs served more than 677,000 Veterans. That total represents approximately 11 percent of the Veteran population receiving VA health care, and accounted for more than 2 million telehealth visits. Of that number, approximately 55 percent were Veterans living in rural areas with limited access to VA healthcare.

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- VistA Evolution development completed for eHMP 1.1 (Basic Viewer)
  - Development initiated for eHMP v1.2.: enhanced viewer with condition-based analysis and user-defined workspaces; provides longitudinal view of full patient record including all VA VistA data, DoD data and available community partner data; also includes text search, multiple charts and graphs and significantly enhanced auditability.

2017 Investments

The 2017 Budget prioritizes funding for projects that have quantifiable Veteran-centered outcomes. Major IT initiatives include:

- The requested $370.1 million for Information Security will support the maintenance of the implementation of cyber security requirements which will evolve the VA cyber posture improving service delivery and collaboration and risk awareness, while improving the security and resiliency of the underlying VA infrastructure facilitating enhanced visibility, access and functionality across the spectrum of VA services for the Veteran.

- The requested $259.9 million for Vista Evolution, Interoperability and VLER Health including $80.7 million for development and $179.2 million in sustainment. Funding in 2017 will contribute to deliver prioritized high value aspects of seamless electronic sharing of interoperable health care data with DoD and community partners through implementation of interoperability standards.

- The requested $143 million for the Veterans Benefits Management System (VBMS) consists of $75 million in development and $68 million in sustainment funds.

- The requested $171.3 million for the Improve Veterans Experience million will deliver and execute an enterprise-wide scalable, commoditized, Veteran-centric, services-based technology environment that will be the foundation for how Veterans are served and how benefits and services are delivered. This new model will provide VA not only an integrated services delivery platform with the approach of placing the Veteran at the center, but will provide best-in-class and industry standard customer service with clear satisfaction and delivery measures.

- The requested $50 million to launch a new Data Management program to use data as a strategic resource. Under this program, VA will inventory its data collection activities with the objective of requesting data from the Veteran only once, and dispose of expired information in a secure and timely way. These two aspects will reduce VA costs for data storage and support safeguards for Veterans' information.

- The request of $44.3 million for the modernization of the Department of Veterans Affairs core accounting system which is a crucial backbone application for the agency. All

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aspects of agency operations depend on proper budgeting, execution of funds, payment of bills, financial reporting, and other functions performed by the core accounting system. These services are critical for VA to service Veterans effectively. They allow facilities to manage a budget, for hospitals to function, for VA suppliers to be paid, for benefits to be managed, and for cemeteries to operate. The current system in use at VA is 30 years old and clearly not sustainable long term. The Financial Management System Modernization (FMS) effort first and foremost will improve the Veterans Experience by ensuring that these essential functions continue into the future.

- The requested $2.5 billion for Sustainment will support the replacement of the oldest hardware that has exceeded its useful lifespan and support server/storage virtualization. Also, the funds will extend the number of national licensing and Enterprise Licensing Agreements.

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Construction

Budget Authority
($ in 000s)

	2015 Actual	2016 Enacted	2017 Request
Major Construction	692,800[1]	1,283,200[2]	528,110
Minor Construction	492,200	406,200	372,069
Grants for State Extended Care Facilities	90,000	120,000	80,000
Grants for State Veterans Cemeteries	46,000	46,000	45,000
TOTAL	**1,321,000**	**1,855,400**	**1,025,179**

1/ Reflects only appropriated transfers into account (does not include $20 million from Supply Fund for Denver transfer)
2/ Reflects transfer of $39 million from Medical Services for Denver (does not reflect unobligated balances transfers)

The Strategic Capital Investment Planning (SCIP) process has served as the basis for prioritizing projects and making VA capital investment funding decisions. Projects requested will correct critical seismic and safety deficiencies, improve access, and address other performance gap issues at VA facilities.

VA's capital requirements are primarily driven by the needs of Veterans to access care in safe, secure, and modern facilities. VA's construction budget demonstrates VA's commitment to address critical major construction projects that directly affect patient safety and reflects VA's promise to provide safe, secure, sustainable and accessible facilities for Veterans. The 2017 budget supports seismic corrections and needed structural improvements, as well as the initial development of two new cemeteries and other gravesite expansions.

The 2017 budget request includes the following major construction projects:

- Seismic and life safety corrections, and clinical expansion in Reno, NV
- Completion of Seismic Corrections, and a Mental Health Unit and Community Living Center in Long Beach, CA
- New National Cemeteries in Western New York and in Southern Colorado
- Gravesite expansion projects in Jacksonville, FL and Lake Worth, FL

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General Administration

Budget Authority
($ in 000s)

	2015 Enacted	2016 Estimate	2017 Request
Office of the Secretary	10,022	10,498	11,589
Office of General Counsel	80,243	92,178	94,317
Office of Management	44,052	44,535	57,729
Office of Human Resources and Administration	61,939	63,555	67,887
Office of Enterprise Integration	24,990	24,743	27,967
Office of Operations, Security and Preparedness	17,884	18,907	20,534
Office of Public Affairs	22,264	21,026	10,736
Office of Government Relations	5,962	7,889	9,208
Office of Acquisition, Logistics & Construction	53,789	53,328	45,424
Veterans Experience Office	...	...	72,568
Transfer	-1,300	...	...
TOTAL	**320,015**	**336,659**	**417,959**

FTE

	2015 Actual	2016 Estimate	2017 Request
Office of the Secretary	91	88	96
Office of General Counsel	713	756	747
Office of Management	257	268	295
Office of Human Resources and Administration	783	893	903
Office of Enterprise Integration	111	340	132
Office of Operations, Security and Preparedness	106	140	163
Office of Public Affairs	78	77	66
Office of Government Relations	42	55	63
Office of Acquisition, Logistics and Construction	405	418	484
Veterans Experience Office	...	...	204
TOTAL	**2,586**	**3,035**	**3,153**

Through the General Administration account, VA Staff Offices provide support for critical operations such as security and emergency preparedness; acquisitions and construction management; legal counsel; financial, budget, and asset management; and legislative review and support to members of Congress and VA's oversight committees. The General Administration account also supports human resources management, project management, corporate-level analysis, public relations and outreach, as well as executive level direction to the Department.

In order to implement initiatives aimed at improving Department level management and oversight, and improving services to Veterans, the 2017 Budget requests $418 million for General Administration, an increase of $81.3 million over 2016.

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MyVA is the initiative that is transforming VA's past way of doing business to one that puts the Veterans in control of how, when, and where they wish to be served. To help accomplish this mission, the Department established a new Veterans Experience Office (VEO) in 2016 under the Office of Enterprise Integration using reimbursements from VA's Administrations. In 2017, the Department is requesting direct appropriations to permanently stand up this office. VEO will represent the voice and perspective of the Veteran in all Department governance and work to develop customer centric programs that will simplify Veterans interactions with VA and help them and their families better understand the services available.

VEO is establishing five Veterans Experience District Offices to provide support to all VA field facilities in carrying out MyVA. These District Offices will work within their own regions to analyze input from Veterans, feedback from front-line employees, industry best practices and VA lessons learned to make recommendations and improve the Veteran experience.

In the 2017 Budget, key initiatives in General Administration include:

- $72.6 million for the new Veteran Experience Office, as described above.

- $8.0 million for business requirements to support the modernization of VA's core Financial Management System (FMS). VA has launched a multi-year effort to replace the Department's 30-year old core Financial System. The end result will be a twenty-first century system that significantly improves the accuracy and transparency of VA's financial management.

- $2.1 million for programs aimed at reducing improper payments.

- $1.4 million to implement the DATA Act requirements to improve the accuracy and transparency of all data reported throughout the Department.

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Office of Inspector General

Budget Authority
($ in 000s)

	2015 Enacted	2016 Enacted	2017 Request
Budget Authority	126,686	136,766	160,106

FTE

	2015 Actual	2016 Enacted	2017 Request
FTE	676	721	821

Over the past year, OIG identified $2.2 billion in actual and potential monetary benefits, and issued 390 audits, health care inspections, contract reviews, evaluations, and administrative investigative reports. OIG operations provided a return on investment of $20 in monetary benefits for each $1 of OIG resources expended. The 2017 Budget supports an expansion initiative for 100 additional FTE at new and existing locations nationwide and ensures that OIG can fulfill its statutory mission to identify waste, fraud, or abuse and make recommendations that help VA provide care and benefits to a growing cohort of veterans with increasingly complex needs.

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Sent from my iPad
Bruce Moskowitz M.D.

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/29/2017 10:34:43 AM
To: (b) (6) aol.com
CC: David Shulkin [drshulkin@aol.com]
Subject: Re: Redesigning the VA system

Can't wait to have you here- we will rock this place- I NEED you by my side!! A big hug!

Sent from my iPhone

On Mar 29, 2017, at 6:21 AM, "(b) (6) aol.com" <(b) (6) aol.com> wrote:

> Very exciting ! Thanks so much for sending this along - I can't wait to start reading. Have a good day Poonam !
>
> Sent from my iPhone
>
> On Mar 29, 2017, at 5:17 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > We are the core innovative, imaginative and transformative team that will bring to reality the big dream of redesigning the VA. I am attaching a good overview of the international health care systems that we may want to learn from and tailor to our veteran needs- so that we build a new delivery system, a system that the nation has never seen. Welcome aboard (b) (6) and to you Secretary Shulkin, we will have to keep you focused!
> >
> > <1857_Mossialos_intl_profiles_2015_v7 (1).pdf>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/29/2017 2:36:45 AM
To: David Shulkin [drshulkin@aol.com]; (b) (6) aol.com
Subject: Redesigning the VA system
Attachments: 1857_Mossialos_intl_profiles_2015_v7 (1).pdf

We are the core innovative, imaginative and transformative team that will bring to reality the big dream of redesigning the VA. I am attaching a good overview of the international health care systems that we may want to learn from and tailor to our veteran needs- so that we build a whole new delivery system that the nation has never seen. Welcome aboard (b) (6) and to Secretary Shulkin, we will have to keep you focused!

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JANUARY 2016

2015 International Profiles of Health Care Systems



AUSTRALIA
CANADA
CHINA
DENMARK
ENGLAND
FRANCE
GERMANY
INDIA
ISRAEL
ITALY
JAPAN
NETHERLANDS
NEW ZEALAND
NORWAY
SINGAPORE
SWEDEN
SWITZERLAND
UNITED STATES

EDITED BY

Elias Mossialos and Martin Wenzl
London School of Economics and Political Science

Robin Osborn and Dana Sarnak
The Commonwealth Fund

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VA-19-0799-D-001579
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THE COMMONWEALTH FUND is a private foundation that promotes a high performance health care system providing better access, improved quality, and greater efficiency. The Fund's work focuses particularly on society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

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VA-19-0799-D-001580

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2015 International Profiles of Health Care Systems

Australia, Canada, China, Denmark, England, France, Germany, India, Israel, Italy, Japan, The Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, and the United States

EDITED BY

Elias Mossialos and Martin Wenzl
London School of Economics and Political Science

Robin Osborn and Dana Sarnak
The Commonwealth Fund

JANUARY 2016

Abstract: This publication presents overviews of the health care systems of Australia, Canada, China, Denmark, England, France, Germany, India, Israel, Italy, Japan, the Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, and the United States. Each overview covers health insurance, public and private financing, health system organization and governance, health care quality and coordination, disparities, efficiency and integration, use of information technology and evidence-based practice, cost containment, and recent reforms and innovations. In addition, summary tables provide data on a number of key health system characteristics and performance indicators, including overall health care spending, hospital spending and utilization, health care access, patient safety, care coordination, chronic care management, disease prevention, capacity for quality improvement, and public views.

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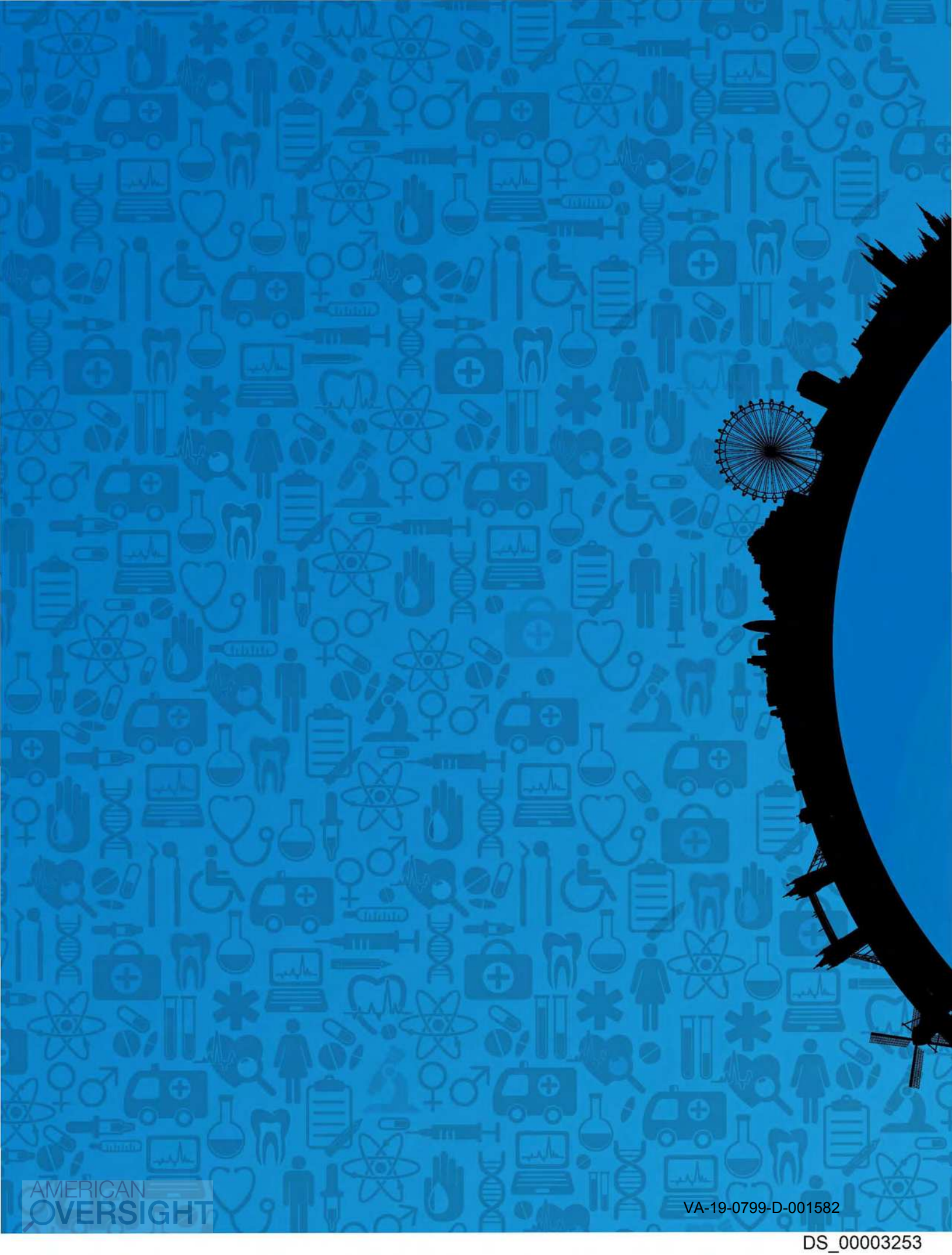

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Table 1. Health Care System Financing and Coverage in 18 Countries

	HEALTH SYSTEM AND PUBLIC/PRIVATE INSURANCE ROLE			BENEFIT DESIGN	
	Government role	Public system financing	Private insurance role (core benefits; cost-sharing; noncovered benefits; private facilities or amenities; substitute for public insurance)	Caps on cost-sharing	Exemptions and low-income protection
Australia	Regionally administered, joint (national & state) public hospital funding; universal public medical insurance program (Medicare)	General tax revenue; earmarked income tax	~47.3% buy complementary (e.g., private hospital and dental care, optometry) and supplementary coverage (increased choice, faster access for nonemergency services, rebates for selected services)	Caps for pharmaceutical OOP expenditure only, dependent on income and total OOP expenditure in the same year	Low-income and older people: Lower cost-sharing, lower pharmaceutical OOP cap and lower OOP maximum for 80% Medicare services rebate[a]
Canada	Regionally administered universal public insurance program that plans and funds (mainly private) provision	Provincial/federal general tax revenue	~67% buy complementary coverage for noncovered benefits (e.g., private rooms in hospitals, drugs, dental care, optometry)	No	There is no cost-sharing for publicly covered services; protection for low-income people from cost of prescription drugs varies by region
China	Supervision by health authorities (Health and Family Planning Commissions) at the national, provincial and local levels; some direct provision through public ownership of hospitals	There are three main publicly financed health insurance types with local-area risk-pooling: urban employer-based (mainly payroll taxes, for formally employed urban residents), urban resident basic (mainly government funded, for urban nonemployed residents), and rural cooperative medical scheme (government-funded, for rural residents)	Complementary to cover cost-sharing and gaps, as well as better health care quality and/or higher reimbursements. No data on coverage, but growth has been rapid.	No	Government subsidies to low-income families for insurance contributions and OOP; emergency assistance by local governments for specific diseases and unpaid emergency department or other expenses
Denmark	National health care system. Regulation, central planning, and funding by national government; provision by regional and municipal authorities	Earmarked income tax	~39% have complementary coverage (cost-sharing, noncovered benefits such as physiotherapy). ~26% have supplementary coverage (access to private providers)	No. Decreasing copayments with higher OOP drug spending.	Drug OOP cap for chronically ill (DKK3,775 [USD498]); financial assistance for low income and terminally ill[a]
England	National health service (NHS)	General tax revenue (includes employment-related insurance contributions)	~11% buy supplementary coverage for more rapid and convenient access (including to elective treatment in private hospitals)	No general cap, but OOP payments almost exclusively apply to prescription drugs and medical appliances only. For drugs, prepayment certificate with GBP29.10 [USD41.10] per three months or GBP104 [USD147] per year ceiling for those needing a large number of prescription drugs.[a]	Drug cost-sharing exemption for low-income, older people, children, pregnant women and new mothers, and some disabled/chronically ill; financial assistance with transport costs available to people with low income; vision tests free for young people, older people, and low-income people
France	Statutory health insurance system, with all SHI insurers incorporated into a single national exchange	Employer/employee earmarked income and payroll tax; general tax revenue, earmarked taxes	~95% buy or receive government vouchers for complementary coverage (mainly cost-sharing, some noncovered benefits); limited supplementary insurance	No. EUR50 [USD60] cap on deductibles for consultations and services[a]	Exemption for low income, chronically ill and disabled, and children
Germany	Statutory health insurance (SHI) system, with 124 competing SHI insurers ("sickness funds" in a national exchange); high income can opt out for private coverage	Employer/employee earmarked payroll tax; general tax revenue	~11% opt out from statutory insurance and buy substitutive coverage. Some complementary (minor benefit exclusions from statutory scheme, copayments) and supplementary coverage (improved amenities).	Yes. 2% of household income; 1% of income for chronically ill.	Children and adolescents <18 years of age are exempt
India	Children and adolescents <18 years of age are exempt	General tax revenue	Limited role (<5% of total expenditure) providing substitutive coverage for the upper class urban population	No. Significant reliance on OOP payments (>70% of total health expenditure).	Various government-financed health insurance schemes for poor and vulnerable population groups to improve access to hospitalization and reduce out-of-pocket payments
Israel	National Health Insurance (NHI) system with four competing, nonprofit health plans. Government distributes the NHI budget among the health plans primarily through capitation	Earmarked income-related tax and general government revenues	Complementary (for benefits such as dental care, drugs, or long-term care) and supplementary coverage (for quicker access and superior service) provided by two types of voluntary insurance: VHI offered by statutory health plans (HP-VHI) (~87% of adult population coverage); commercial VHI (C-VHI) (~53% coverage); C-VHI tend to be more comprehensive and more expensive.	Not overall. Caps on OOP for drugs (chronically ill only) and specialist visits (at household level)	Quarterly OOP caps for drugs for the chronically ill and age-, income-, and health status-related discounts; copayment exemptions for Holocaust survivors; age-, income-, disability-, and health status-related exemptions on copayments for specialist consultations; reduced health tax (3% instead of 5%) for people with low incomes
Italy	National health care system. Funding and definition of minimum benefit package by national government, planning, regulation and provision by regional governments.	National earmarked corporate and value-added taxes; general tax revenue and regional tax revenue	~15% buy complementary (services excluded from statutory benefits) or supplementary coverage (more amenities in hospitals, wider provider choice)	No. Max EUR46.15 [USD61] copayment per outpatient specialist consultation or diagnostic procedure; limited copayment (regional rates) on drugs.[a]	Exemptions for low-income older people/children, pregnant women, chronic conditions/disabilities, rare diseases
Japan	Statutory health insurance system, with >3,400 noncompeting public, quasi-public, and employer-based insurers. National government sets provider fees, subsidizes local governments, insurers, and providers and supervises insurers and providers.	General tax revenue; insurance contributions	Majority of population have coverage for cash benefits in case of sickness, usually together with life insurance. Limited role of complementary and supplementary insurance offered separately from life insurance.	Yes. Coinsurance reduced to, e.g., 1% after JPY80,100 [USD761] monthly cap, depending on enrollee age and income. Annual cap of total OOP payments at between JPY340,000 [USD3,230] and JPY1.26M [USD11,970] per household, depending on income and ages of household members.[a]	Low-income monthly OOP ceiling: JPY35,400 [USD336]; reduced cost-sharing for young children, older people, those with chronic conditions, mental illness and disabilities. Tax-funded health services for those on social assistance.[a]
Netherlands	Statutory health insurance system, with universally-mandated private insurance (national exchange); government regulates and subsidizes insurance	Earmarked payroll tax; community-rated insurance premiums; general tax revenue	Private plans provide statutory benefits; 84% buy complementary coverage for benefits excluded from statutory package such as dental care, alternative medicine, physiotherapy, eyeglasses, contraceptives and copayments	No, but annual deductible of EUR375 [USD455] covers most cost-sharing[a]	GP care and children exempt from cost-sharing; premium subsidies for low-income
New Zealand	National health care system. Responsibility for planning, purchasing, and provision devolved to geographically defined District Health Boards.	General tax revenue	~33% buy complementary coverage (for cost-sharing, specialist fees, and elective surgery in private hospitals) and supplementary coverage for faster access to nonurgent treatment	No. Reduced fees after 12 doctor visits per year/patient and no drug copayments after 20 prescriptions per year/family	No primary care consultation charges for children under age 13; subsidies for low-income, some chronic condition and high-need groups, Maori and Pacific Islanders
Norway	National health care system. Some direct funding and provision roles for national government and some responsibilities devolved to Regional Health Care Authorities and municipalities.	General tax revenue, national and municipal taxes	~8% holds supplementary VHI, mainly bought by employers for providing employees quicker access to publicly covered elective services and choice among private providers.	Yes. Overall annual cost sharing ceiling is NOK2,105 [USD223].[a]	Exemptions for children < 16 yrs. somatic, <18yrs psychiatric, pregnant women, for some communicable diseases (including STDs); those with work-related injuries; low-income groups receive free essential drugs and nursing care
Singapore	Government subsidies at public health care institutions and some providers; Medisave: mandatory medical savings program for routine expenses; MediShield: catastrophic health insurance; Medifund: government endowment fund to subsidize health care for low-income and those with large bills. Government regulation of private insurance, central planning and financing of infrastructure and some direct provision through public hospitals and clinics.	General tax revenue	Medisave-approved Integrated Shield Plans (private insurance plans) supplement MediShield coverage to provide catastrophic health coverage for additional ward classes. Other types of private insurance are also available, including private insurance provided by employers.	No.	Subsidized care for low-income population, with income- and asset-based means-test to target subsidies. Medifund as safety net to pay for low-income and people with no means to pay for their health care bills.
Sweden	National health care system. Regulation, supervision, and some funding by national government; responsibility for most financing and purchasing/provision devolved to county councils	Mainly general tax revenue raised by county councils; some national tax revenue	~10% of all employed individuals ages 15–74 get supplementary coverage from employers for quicker access to a specialists and elective treatment	Yes. SEK1,100 [USD123] for health services and SEK 2,200 [USD246] for drugs.[a]	Some cost-sharing exemptions for children, adolescents, pregnant women, and elderly.
Switzerland	Statutory health insurance system, with universally mandated private insurance (regional exchanges), some federal legislation, with cantonal (state) government responsible for provider supervision, capacity planning, and financing through subsidies	Community-rated insurance premiums; general tax revenue	Private plans provide universal core benefits; some people buy complementary (services not covered by statutory insurance) and supplementary (improved amenities and access); no coverage data available	Yes. CHF700 [USD511] maximum after deductible.[a]	Some copayment exemptions and CHF350 [USD255] cap for <19-year-olds; income-related premium assistance (28% receive); maternity care fully covered[a]
United States	Medicare: age 65 and older, some disabled; Medicaid: some low-income; for those without employer coverage, state-level insurance exchanges with income-based subsidies; insurance coverage mandated, with some exemptions (10.4% of adults uninsured)	Medicare: payroll tax; premiums, federal tax revenue; Medicaid: federal, state tax revenue	Primary private voluntary insurance covers ~66% of population (employer-based and individual); supplementary for Medicare	Yes for most private insurance plans: $6,600 yearly limit for individuals; $13,200 for families as of 2015	Yes for most private insurance plans: $6,600 yearly limit for individuals; $13,200 for families as of 2015

[a] All bracketed figures in USD were converted from local currency using the purchasing power parity conversion rate for GDP in 2014 reported by the Organisation for Economic Co-operation and Development (2015).

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Table 2. Selected Health Care System Indicators for 17 Countries

		Australia	Canada	China[o]	Denmark	France	Germany	Israel	Italy	Japan	Netherlands	New Zealand	Norway	Singapore	Sweden	Switzerland	United Kingdom	United States
Population, 2013	Total population (millions)	23.132[c]	35.317	1,360.720	5.615	63.790	80.646	8.057	60.233	127.296	16.804	4.472	5.080	5.312[g]	9.600	8.089	64.107	316.129
	Percentage of population over age 65	14.4%	15.2%	9.7%	17.8%	17.7%	21.1%	10.7%	21.0%	25.1%	16.8%	14.2%	15.6%	10.0%[g]	19.0%	17.3%	17.1%	14.1%
Spending, 2013 (unless otherwise noted)	Percentage of GDP spent on health care	9.4%[a]	10.7%	5.4%	11.1%	11.6%	11.2%	7.4%[b]	n/a	10.2%	11.1%[e]	11.0%	9.4%	4.7%[g]	11.5%	11.1%[a]	8.8%	17.1%
	Health care spending per capita[d]	$4,115[a]	$4,569	$636	$4,847	$4,361	$4,920	$2,232[b]	n/a	$3,713	$5,131[c]	$3,855	$6,170	$2,881[h]	$5,153	$6,325[e]	$3,364	$9,086
	Average annual growth rate of real health care spending per capita, 2009–13	2.42%[i]	0.22%	15.41%	–0.17%	1.35%	1.95%	2.61%[m]	n/a	3.83%	1.73%[e]	0.82%	1.40%	n/a	6.95%[e]	2.54%[m]	–0.88%	1.24%
	Out-of-pocket health care spending per capita[d]	$771[a]	$623	$216	$625	$277	$649	$627	$666	$503[a]	$270	$420	$855	n/a	$726	$1,630	$321	$1,074
	Hospital spending per capita[d]	$1,645[a]	$1,338	$392	$2,070	$1,600	$1,423	$772[b]	n/a	1,673[a]	$1,849	n/a	$2,285[n]	n/a	$1,907	$2,289	n/a	$2,964
	Spending on pharmaceuticals per capita[d]	$590[a]	$761	$263[n]	$288	$622	$678	287[b]	$572	$756[a]	$397	n/a	$437	n/a	$496	$696	n/a	$1,034
Physicians, 2013 (unless otherwise noted)	Number of practicing physicians per 1,000 population	3.39	2.48[a]	2.04	3.62[a]	3.10	4.05	3.43	3.90	2.29[a]	n/a	2.81	4.31	1.9[g,f]	4.01[a]	4.04	2.77	2.56
	Average annual number of physician visits per capita	7.1	7.7[a]	5.4	4.6	6.4	9.9	n/a	6.8	12.9[a]	6.2	3.7[a]	4.2	n/a	2.9	3.9[a]	n/a	4.0[c]
Hospital spending, utilization, and capacity, 2013 (unless otherwise noted)	Number of acute care hospital beds per 1,000 population	3.36[a]	1.71[a]	4.55	2.47	3.35	5.34	1.90	2.75[b]	7.92	3.32[a]	2.59	2.29	2.0[j,k]	1.94	2.91	2.28	2.48[a]
	Hospital spending per discharge[d]	$9,529[a]	$15,916[a]	$2,033	$11,471[c]	$9,622	$5,641	$4,797[b]	n/a	$14,408[b]	14,980[a]	n/a	$11,361[c]	n/a	n/a	$13,437[a]	n/a	$20,991[c]
	Hospital discharges per 1,000 population	173[a]	83[a]	140	172[c]	166	252	159	124	111[b]	119[a]	146	175[c]	n/a	163[c]	166[a]	129	125[c]
	Average length of stay for curative care (days)	4.8[a]	7.6[a]	8.9	n/a	5.7[a]	7.7	4.3	6.8	17.2	6.4[a]	5.3	5.5	n/a	5.6[a]	5.9	5.9	5.4[b]
Medical technology, 2013 (unless otherwise noted)	Magnetic resonance imaging (MRI) machines per million population	13.4	8.8	3.2[p]	n/a	9.4	n/a	3.1	24.6[a]	46.9[b]	11.5	11.2	n/a	8.3[k,c]	n/a	n/a	6.1	35.5
	MRI exams per 1,000 population	27.6	52.8	42.7[p]	60.3	90.9	n/a	30.5	n/a	n/a	50.0[b]	n/a	n/a	n/a	n/a	n/a	n/a	106.9
IT, 2015	Physicians' use of EMRs (% of primary care physicians)[l]	92%	73%	n/a	n/a	75%	84%	n/a	n/a	n/a	98%	100%	99%	n/a	99%	54%	98%	84%
Health risk factors, 2013 (unless otherwise noted)	Percentage of adults who report being daily smokers	12.8%	14.9%	28.1%[q]	17%	24.1%[a]	20.9%	16.2%	21.1%	19.3%	18.5%	15.5%	15.0%	13.3%[k]	10.7%	20.4%[a]	20.0%[a]	13.7%
	Obesity (BMI>30) prevalence	28.3%[b]	25.8%	11.9%[q]	14.2%[n]	14.5%[a,n]	23.6%	15.7%[n]	10.3%[n]	3.7%	11.1%[n]	30.6%	10.0%[a,n]	10.8%[k,c]	11.7%[n]	10.3%[a,n]	24.9%	35.3%[a]

Source: OECD Health Data 2015 (November) unless otherwise noted.
[a] 2012.
[b] 2011.
[c] 2010.
[d] Adjusted for differences in the cost of living.
[e] Current spending only, and excludes spending on capital formation of health care providers.
[f] Commonwealth 2015 Survey of Primary Care Physicians.
[g] Source: World Bank, 2014.
[h] Source: World Bank, 2014; 2005 purchasing power parity (PPP) adjustment.
[i] Source: World Bank, 2014; may include chronic care beds as well as acute care beds.
[j] Source: World Health Organization, 2014.
[k] Source: Singapore Health Promotion Board, 2014.
[l] 2009–12.
[m] 2009–11.
[n] Self-reported as opposed to measured data.
[o] China indicators are from China Health and Family Planning Statistical Yearbook 2014 unless otherwise noted.
[p] Calculated by using data from China Health and Family Planning Statistical Yearbook and Gu, X., D. He, X. Hu et al., Forecast analysis of MRI allocation in China. China Health Resources 2013, 16(1):41–43.
[q] National Health and Family Planning Commission of China, 2015. Report on Nutrition and Non-communicable Disease Status of Chinese Residents 2015.
[r] China National Health Development Research Center. China National Health Accounts Report 2014.

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Table 3. Selected Health System Performance Indicators for 11 Countries

		Australia	Canada	France	Germany	Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	United States
Adults' access to care, 2013	Able to get same-day/next-day appointment when sick	58%	41%	57%	76%	63%	72%	52%	58%	n/a	52%	48%
	Very/somewhat easy getting care after hours	46%	38%	36%	56%	56%	54%	58%	35%	49%	69%	39%
	Waited 2 months or more for specialist appointment[a]	18%	29%	18%	10%	3%	19%	26%	17%	3%	7%	6%
	Waited 4 months or more for elective surgery[b]	10%	18%	4%	3%	1%	15%	22%	6%	4%	n/a	7%
	Experienced access barrier because of cost in past year[c]	16%	13%	18%	15%	22%	21%	10%	6%	13%	4%	37%
Safety problems among sicker adults, 2014[d,e]	Health professional did not review their prescriptions in past year	16%	16%	47%	19%	37%	23%	37%	48%	27%	21%	14%
Care coordination and transitions among older adults, 2014[f]	Experienced a coordination problem in past 2 years[g]	21%	32%	7%	41%	21%	20%	37%	24%	29%	24%	35%
	Experienced gaps in hospital discharge planning in past 2 years[g]	41%	44%	54%	56%	59%	n/a	70%	67%	56%	38%	28%
Chronic care management among older adults, 2014[h,i]	Had a treatment plan they could carry out in daily life	80%	76%	62%	30%	41%	64%	53%	41%	47%	73%	83%
	Between visits, has health care professional they can contact to ask questions or to get advice	65%	67%	53%	43%	83%	75%	55%	75%	58%	71%	84%
Primary care practices receive performance feedback, 2015	Routinely receives and reviews clinical outcomes data	35%	23%	43%	44%	88%	65%	32%	79%	9%	86%	52%
	Routinely receives and reviews patient satisfaction and experience data	46%	17%	3%	25%	61%	60%	9%	88%	15%	88%	63%
	Routinely receives data comparing performance to other practices	13%	17%	49%	29%	42%	61%	4%	55%	37%	71%	37%
OECD health care quality indicators[j]	Diabetes lower extremity amputation rates per 100,000 population, 2013	4.5	7.4	7.5	9.2	4.7[k]	5.9[l]	5.7	4.1	3.1[l]	3.1	n/a
	Breast cancer five-year survival rate, 2008–2013 (or nearest period)	88%[q]	n/a	86.2%	85.8%[r]	85.3%	86.0%	89.8%[l]	89.4%	n/a	81.1%	88.9%[s]
	Mortality after admission for acute myocardial infarction per 100 admissions over age 45, 2013[g]	4.1[m]	6.7	7.2	8.7	7.6[m,k]	6.6	6.7	4.5[m]	7.7	7.6	5.5
Avoidable deaths, 2013	Mortality amenable to health care[h] (deaths per 100,000 population)	68[k]	78[k]	64[k]	88	72	89[k]	69	72	n/a	86	115[l]
Prevention, 2013[j]	Percentage of children with measles immunization	94%	95%	89%	97%	96%	92%	93%	97%	93%	95%	91%
	Percentage of population over age 65 with influenza immunization	n/a	64%	52%	58.6%[l]	69%	69%	21%	46%	46%[l]	76%	67%[l]
Public views of health system, 2013	Works well, minor changes needed	48%	42%	40%	42%	51%	47%	46%	44%	54%	63%	25%
	Fundamental changes needed	43%	50%	49%	48%	44%	45%	42%	46%	40%	33%	48%
	Needs to be completely rebuilt	9%	8%	11%	10%	5%	8%	12%	10%	7%	4%	27%

Sources (unless noted otherwise): 2013, 2014, and 2015 Commonwealth Fund International Health Policy Surveys.

[a] Base: Saw or needed to see a specialist in past two years.

[b] Base: Needed elective surgery in past two years.

[c] Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

[d] Test results/medical records not available at time of appointment and/or doctors ordered medical test that had already been done; received conflicting information from different doctors; and/or specialist lacked medical history or regular doctor was not informed about specialist care.

[e] When discharged from the hospital: you did not receive written information about what to do when you returned home and symptoms to watch for; hospital did not make sure you had arrangements for follow-up care; someone did not discuss with you the purpose of taking each medication; and/or you did not know who to contact if you had a question about your condition or treatment. Base: hospitalized overnight in the past two years.

[f] Base: Has a regular doctor or place of care.

[g] In-hospital case-fatality rates within 30 days of admission.

[h] Source: WHO Mortality files (number of deaths by age group) and populations (except Human Mortality Database for CAN, UK, and US). List of amenable causes: Nolte E, McKee M. Variations in amenable mortality—Trends in 16 high-income nations. Health Policy. 2011 Sep.

[i] Source: OECD Health Data 2015.

[j] 2012.

[k] 2011.

[l] 2010.

[m] Admissions resulting in a transfer are included.

[n] Who had at least one chronic condition.

[o] Age 65 or older.

[p] Who are taking four or more prescription medications regularly.

[q] 2006–11.

[r] 2006–12.

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Table 4. Provider Organization and Payment in 18 Countries

	Provider ownership		Provider payment		Primary care role	
	Primary care	Hospitals	Primary care payment	Hospital payment	Registration with GP required	Gatekeeping
Australia	Private	Public (~65% of beds), private (~35%)	~95% FFS, ~5% incentive payments	Global budgets and case-based payment in public hospitals (includes physician costs); FFS in private hospitals	No	Yes
Canada	Private	Public/private mix (proportions vary by region), mostly not-for-profit	Mostly FFS (~45%–85%, depending on province), but some alternatives (e.g., capitation) for group practices	Mostly global budgets, case-based payment in some provinces (does not include physician costs)	Not generally, but yes for some capitation models	Yes, mainly through financial incentives varying across provinces: e.g., in most provinces, specialists receive lower fees for patients not referred
China	Private/public mix (private village doctors and clinics; public township and community hospitals providing GP services)	Public (~55%)/private (~45%) mix (mainly public in rural areas, public and private in urban areas)	FFS for private providers, salaries and FFS for GPs employed by hospitals	Mainly FFS, with some pilot projects using case-based payments, capitation, or global budgets	Not generally, with exceptions in some areas	Not generally, with exceptions in some areas
Denmark	Private	Almost all public	~70% FFS, ~30% capitation	Mainly global budgets and case-based payments (includes physician costs)	Yes (for 98% of population)	Yes (for 98% of population)
England	Mainly private, limited number of NHS-owned practices with salaried physicians	Mostly public, some private	Mix capitation/FFS/P4P; salary payments for a minority (the salaried GPs are employees of private group practices, not of the NHS)	Mainly case-based payments (60%) plus budgets for mental health, education, and research and training. All include physician costs, drug costs, etc.	Yes	Yes
France	Private	Mostly public (67% of capacity), some private for-profit (25%) and private not-for-profit	Mix FFS/P4P/flat EUR40 [USD48] bonus per year per patient with chronic disease and regional agreements for salaried GPs[a]	Mainly case-based payments (includes physician costs in public hospitals but not in private) and non-activity-based grants for education, research, etc.	No, but many patients register voluntarily	Voluntary but incentivized: higher cost-sharing for visits and prescriptions without a referral from the physician with which patients registered
Germany	Private	Public (~50% of beds); private nonprofit (~33%), private for-profit (~17%)	FFS	Case-based payment (includes physician costs)	No	Generally no, present in specific programs by sickness funds
India	Mainly public, some private in urban areas	Private non- and for-profit (~63% of beds) and public	Salary for staff at public providers, FFS (paid OOP) for private providers	Global budgets for public hospitals	No	No
Israel	Nonprofit, either salaried by Health Plan or Health Plan contractors	Public (~50%), private nonprofit (including health plans, ~45%), private for-profit (~5%)	Mainly capitation and some FFS to private providers, salary if owned by health plan		Yes in the largest health plan (Clalit), no in the other three	Yes in two of the four health plans (including the largest, Clalit), no in the other two
Italy	Private	Mostly public (~80% of beds), some private (~20%)	Mix capitation (~70% of total), FFS and limited P4P (~30%)	Subject to regional variation, mainly case-based payment (except hospitals owned by regional authorities) and global budgets (includes physician costs)	Yes	Yes
Japan	Mostly private	Mainly private nonprofit (~80% of beds), some public (~20%)	Most FFS, some per-case daily or monthly payments	Case-based per diem payments plus FFS, or FFS only (includes physician costs)	No	No, but some large hospitals and academic centers charge extra fees to patients not referred
Netherlands	Private	Mostly private, nonprofit	Mix capitation and FFS for 'core' activities (75% in total), some bundled payments and P4P negotiated with insurers	Mainly case-based payment (include physician costs)	No, but most patients register voluntarily	Yes
New Zealand	Private	Mostly public, some private	Mix capitation (~50% of total), FFS patient payments (~50%)	Global budgets (includes physician costs)	No	Yes
Norway	Mainly private (95% of general practitioners)	Almost all public, some private not-for-profit, some for-profit hospitals offering elective treatment only	GPs: Capitation from municipal contracts (~35% of income), government-sponsored FFS (~35%) and user-charges (~30%)	Somatic: Global budgets (~50%) plus case-based payment (~50%) (includes physician costs); Psychiatric: 100% global budgets	No, but more than 95% of patients register voluntarily	Yes
Singapore	Almost all private, with some larger public clinics for lower-income population	Mainly public, 20%–30% private based on activity	FFS	For public hospitals, combination of global budgets and case-based payments	No	No
Sweden	Mixed, ~40% private ~60% public	Almost all public, some private for- and not-for-profit	Mix capitation (~80% of total) and FFS/limited P4P (~20%)	Global budgets (~66% of total) and case-based payment/limited P4P (includes physician costs)	Yes, in all counties except Stockholm	No
Switzerland	Private	Mostly public or publicly subsidized private, some private	Most FFS, some capitation in managed care plans offered by insurers	Case-based payments (~50% of total) and subsidies (through various mechanisms) from cantonal government	No, except in some managed care plans offered by insurers	No, except in some managed care plans with gatekeeping offered by insurers
United States	Private	Mix of nonprofit (~70% of beds), public (~15%), and for-profit (~15%)	Most FFS, some capitation with private plans; some incentive payments	Mostly per-diem and case-based payments (usually does not include physician costs)	No	In some insurance programs

[a] Bracketed figure in USD was converted from local currency using the purchasing power parity conversion rate for GDP in 2014 reported by the Organisation for Economic Co-operation and Development (2015).
Notes: FFS = fee-for-service; P4P = pay-for-performance; GP = general practitioner; NHS = National Health Service; OOP = out-of-pocket.

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The Australian Health Care System, 2015

Lucinda Glover



What is the role of government?

Three levels of government are collectively responsible for providing universal health care: federal; state and territory; and local. The federal government mainly provides funding and indirect support to the states and health professions, subsidizing primary care providers through the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and providing funds for state services. It has only a limited role in direct service delivery.

States have the majority responsibility for public hospitals, ambulance services, public dental care, community health services, and mental health care. They contribute their own funding in addition to that provided by federal government. Local governments play a role in the delivery of community health and preventive health programs, such as immunization and regulation of food standards (Department of the Prime Minister and Cabinet, 2015).

Who is covered and how is insurance financed?

Publicly financed health insurance: Total health expenditure in 2013–2014 represented 9.8 percent of gross domestic product (GDP), an increase of 3.1 percent from 2012–2013. Two thirds of this expenditure (67.8%) came from 2012–2013 (Australian Institute of Health and Welfare [AIHW], 2015).

The federal government funds Medicare, a universal public health insurance program providing free or subsidized access to care for Australian citizens, residents with a permanent visa, and New Zealand citizens following their enrollment in the program and confirmation of identity (AIHW, 2014). Restricted access is provided to citizens of certain other countries through formal agreements (Department of Human Services [DHS], 2015). Other visitors to Australia do not have access to Medicare. Government funding is raised an estimated AUD10.3 billion (USD6.7 billion) in 2013–2014 (The Commonwealth of Australia, 2013). (In July 2014, the levy was expanded to raise funds for disability care.)

Private health insurance: Private health insurance (PHI) is readily available and offers more choice of providers (particularly in hospitals), faster access for nonemergency services, and rebates for selected services. Government policies encourage enrollment in PHI through a tax rebate and, above a certain income, a penalty payment for not having PHI (the Medicare Levy surcharge) (PHIO, 2015). The Lifetime Health Coverage program provides a lower premium for life if participants sign up before age 31. There is a 2 percent increase in the base premium for every year after age 30 for people who do not sign up. Consequently, take-up is highest for this age group but rapidly drops off as age increases, with a trend to opt out at age 50 and up.

Nearly half of the Australian population (47%) had private hospital coverage and nearly 56 percent had general treatment coverage in 2015 (Private Health Insurance Administration Council, 2015).

Insurers are a mix of for-profit and nonprofit providers. In 2013–2014, private health insurance expenditures represented 8.3 percent of all health spending (AIHW, 2015).

Private health insurance can include coverage for hospital, general treatment, or ambulance services. When accessing hospital services, patients can opt to be treated as a public patient (with full fee coverage) or as a private patient (with 75% fee coverage). For private patients, insurance covers the MBS fee. If a provider charges above the MBS fee, the consumer will bear the gap cost unless they have gap coverage. The patient

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may also be charged for costs such as hospital accommodation, surgery fees (implants and theater fees), and diagnostic tests.

General coverage provides insurance for dental, physiotherapy, chiropractic, podiatry, home nursing, and optometry services. Coverage may be capped by dollar amount or number of services.

Private health insurance coverage varies by socioeconomic status. PHI covers just one-third of the most disadvantaged 20 percent of the population, a proportion that rises to more than 79 percent for the most advantaged population quintile. This disparity is due in part to the Medicare Levy surcharge applied to higher-income earners (Australian Bureau of Statistics [ABS], 2013).

What is covered?

Services: The federal government defines Medicare benefits, which include hospital care, medical services, and pharmaceuticals, to name a few. States provide further funding and are responsible for the delivery of free public hospital services, including subsidies and incentive payments in the areas of prevention, chronic disease management, and mental health care. The MBS provides for limited optometry and children's dental care.

Pharmaceutical subsidies are provided through the PBS. Pharmaceuticals need to be approved for cost-effectiveness by the independent Pharmaceutical Benefits Advisory Committee (PBAC) to be listed. War veterans, the widowed, and their dependents may be eligible for the Repatriation PBS (DHS, 2015).

Nearly half (49%) of federal support for mental health is for payments to people with a disability; remaining support goes to payments to states, payments and allowances for caregivers, and subsidies provided through the MBS and PBS (National Mental Health Commission, 2014). State governments are responsible for specialist and acute mental care services.

Home care for the elderly and hospice care coverage are described below in the section "How is the delivery system organized and financed?"

Cost-sharing and out-of-pocket spending: Out-of-pocket payments accounted for 18 percent of total health expenditures in 2013–2014. The largest share (38%) was for medications, followed by dental care (20%), medical services (e.g., referred and unreferred private health insurance), medical aids and equipment, and other health practitioner services (AIHW, 2015).

There are no deductibles or out-of-pocket costs for public patients receiving public hospital services. General practitioner (GP) visits are subsidized at 100 percent of the MBS fee, and specialist visits at 85 percent. GPs and specialists can choose whether to charge above the MBS fee. About 83 percent of GP visits were provided without charge to the patient in 2014–2015. Patients who were charged paid an average of AUD31 (USD20) (DH, 2015).

Out-of-pocket pharmaceutical expenditures are capped. In 2015 the maximum cost per prescription for low-income earners was set at AUD6.10 (USD3.97) with an annual cap of AUD366 (USD238). For the general population, the cap per prescription is AUD37.70 (USD24.55) per prescription, which reverts to the low-income rate cap if they incur more than AUD1,454 (USD947) in out-of-pocket expenditure within a year.[1] Consumers pay the full price of medicines not listed on the PBS. Pharmaceuticals provided to inpatients in public hospitals are generally free.

Safety nets: Beginning in January 2016, a new Medicare Safety Net will replace the previous Original Medicare Safety Net, the Extended Medicare Safety Net, and the Greatest Permissible Gap arrangements. Medicare will reimburse 80 percent of out-of-pocket costs (up to a cap of 150 percent of the MBS fee) for the remainder of the calendar year once annual thresholds are met: AUD400 (USD260) for concessional patients (including

[1] Please note that, throughout this profile, all figures in USD were converted from AUD at a rate of about AUD1.54 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Australia.

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low-income adults, children under 16, and certain veterans); AUD700 (USD456) for parents of school children and singles; and AUD1,000 (USD651) for all other families.

How is the delivery system organized and financed?

Primary care: In 2013, there were 25,702 GPs, and a slightly higher number of specialists (27,279) (AIHW, 2015a). GPs are typically self-employed, with about four per practice on average (DH, 2015, and DHS, 2015). In 2012 those in nonmanagerial positions earned an average of AUD2,862 (USD1,864) per week. The schedule of service fees is set by the federal health minister through the MBS.

Registration with a GP is not required, and patients choose their primary care doctor. GPs operate as gatekeepers, in that a referral to a specialist is needed for a patient to receive the MBS subsidy for specialist services. The fee-for-service MBS model accounts for the majority of federal expenditures on GPs, while the Practice Incentives Program (PIP) accounts for 5.5 percent (ANAO, 2010).

State community health centers usually employ a multidisciplinary provider team. The federal government provides financial incentives for the accreditation of GPs, multidisciplinary care approaches, and care coordination through PIP and through funding of GP Super Clinics and Primary Health Networks (PHNs). PHNs (which replace Medicare Locals) are being implemented in 2015–2016 to support more efficient, effective, and coordinated primary care.

The number of nurses working in primary care has been increasing, from 8,649 registered or enrolled nurses primarily working in a general practice setting in 2011 to 11,370 in 2014. Their role has been expanding with the support of the PIP practice nurse payment. Beyond this, nurses are funded through practice earnings. Nurses in general practice settings provide chronic disease management and care coordination, preventive health education, and oversight of patient follow-up and reminder systems (Health Workforce Australia [HWA], 2015).

Outpatient specialist care: Specialists delivering outpatient care are either self-employed in a solo private practice (6,745 specialists in 2013) or employed in a group practice (5,257) (HWA, 2015). Patients are able to choose which specialist they see, but must be referred by their GP to receive MBS subsidies. Specialists are paid on a fee-for-service basis. They receive a subsidy through the MBS of 85 percent of the schedule fee and set their patients' out-of-pocket fees independently. Many specialists split their time between private and public practice.

Administrative mechanisms for direct patient payments to providers: Many practices have the technology to process claims electronically so that reimbursements from public and private payers are instantaneous, and patients pay only their copayment (if the provider charges above the MBS fee). If the technology is not in place, patients pay the full fee and seek reimbursement from Medicare and/or their private insurer.

After-hours care: GPs are required to ensure that after-hours care is available to patients, but are not required to provide care directly. They must demonstrate that processes are in place for patients to obtain information about after-hours care, and that patients can contact them in an emergency. After-hours walk-in services are available, and may be provided in a primary care setting or within hospitals. As there is free access to emergency departments, these also may be utilized for after-hours primary care.

The federal government provides varying levels of practice incentives for after-hours care, depending on whether access is direct or provided indirectly through arrangements with other practitioners in the area. Government also funds PHNs to support and coordinate after-hours services, and there is an after-hours advice and support line.

Hospitals: In 2013–2014 there were 747 public hospitals (728 acute, 19 psychiatric) with a total of 58,600 beds and 612 private hospitals (326 day hospitals and 286 other) with 31,000 beds (AIHW, 2014a; AIHW, 2014b). Private hospitals are a mix of for-profit and nonprofit.

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Public hospitals receive a majority of funding (91%) from federal and state governments, with the remainder coming from private patients and their insurers. Most of the funding (62% of the total) is for public physician salaries. Private physicians providing public services are paid on a per-session or fee-for-service basis. Private hospitals receive most of their funding from insurers (47%), federal government's rebate on health insurance premiums (21%), and private patients (12%) (AIHW, 2014b).

Public hospitals are organized into Local Hospital Networks (LHNs), of which there were 138 in 2013–2014. These vary in size, depending on the population they serve and the extent to which linking services and specialties on a regional basis is beneficial. In major urban areas, a number of LHNs comprise just one hospital.

State governments fund their public hospitals largely on an activity basis using diagnosis-related groups. Federal funding for public hospitals includes a base level of funding, with growth funding set at 45 percent of the "efficient price of services" of activities, determined by the Independent Hospital Pricing Authority (IHPA [http://www.ihpa.gov.au]). States are required to cover the remaining cost of services, providing an incentive to keep costs at the efficient price or lower. Small rural hospitals are funded through block grants (IHPA, 2015). Starting in July 2017, the federal government will return to block-grant funding for all hospitals.

Mental health care: Mental health services are provided in many different ways, including by GPs and specialists, in community-based care, in hospitals (both in- and outpatient, public and private), and in residential care. GPs provide general care and may devise treatment plans of their own or refer patients to specialists. Specialist care and pharmaceuticals are subsidized through the MBS and PBS.

State governments fund and deliver acute mental health and psychiatric care in hospitals, community-based services, and specialized residential care. Public hospital-based care is free to public patients (AIHW, 2015b).

The federal government has commissioned the National Mental Health Commission to undertake a review of all existing services (NMHC, 2015).

Long-term care and social supports: The majority of people living in their own homes with severe or profound limitations in core activities receive informal care (92%). Thirty-eight percent receive only informal assistance and 54 percent receive a combination of informal and formal assistance. In 2009, 12 percent of Australians were informal caregivers and around 30 percent of those were the primary caregiver (carer). In 2011–2012, federal government provided AUD3.18 billion (USD2.07 billion) under the income-tested Carer Payment program, and AUD1.75 billion (USD1.14 billion) through the Carer Allowance (not income-tested, and offered as a supplement for daily care). Government also provides an annual Carer Supplement of AUD480 million (USD313 million) to help with the cost of caring. Recipients of the Carer Allowance who care for a child under the age of 16 receive an annual Child Disability Assistance Payment of AUD1,000 (USD651). There are also a number of respite programs providing further support for caregivers (AIHW, 2013).

Home care for the elderly is provided through the Commonwealth Home Support Program in all states except Western Australia. Subsidies are income-tested and may require copayments from recipients. Services can include assistance with housework, basic care, physical activity, nursing, and allied health. The program began in July 2015 as a consolidation of home and community care, planned respite for caregivers, day therapy, and assistance with care and housing (Department of Social Services, 2015). The Western Australian Government administers and delivers its Home and Community Care Program with funding support from federal government.

Aged care homes may be private nonprofit or for-profit, or run by state or local governments. Federally subsidized residential aged care positions are available for those who are approved by an Aged Care Assessment Team. Hospice care is provided by states through complementary programs funded by the Commonwealth. The Australian Government supports both permanent and respite residential aged care. Eligibility is determined through a needs assessment, and permanent care is means-tested (AIHW, 2015c).

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In 2013, the federal government, in partnership with states, implemented the pilot phase of the National Disability Insurance Scheme. The scheme provides more-flexible funding support (not means-tested), allowing greater tailoring of services.

What are the key entities for health system governance?

Intergovernmental collaboration and decision-making at the federal level occur through the Council of Australian Governments (COAG), with representation from the Prime Minister and first ministers of each state. The COAG focuses on the highest-priority issues, such as major funding discussions and the interchange of roles and responsibilities between governments. The COAG Health Council is responsible for more detailed policy issues and is supported by the Australian Health Ministers Advisory Council (http://www.coaghealthcouncil.gov.au/).

The federal Department of Health (DH) oversees national policies and programs such as the MBS and PBS. Payments through these schemes are administered by the Department of Human Services. The PBAC provides advice to the Minister for Health on the cost-effectiveness of new pharmaceuticals (but not routinely on delisting).

Several national agencies and the state governments are responsible for quality and safety of care (see below). The AIHW and the Australian Bureau of Statistics (ABS) are the major providers of health data.

Regulatory oversight is provided by a number of agencies, such as the Therapeutic Goods Administration, which oversees supply, imports, exports, manufacturing, and advertisement; the Australian Health Practitioner Regulation Agency, which ensures registration and accreditation of the workforce in partnership with National Boards; and the Australian Prudential Regulation Authority, for private health insurance. The Australian Competition and Consumer Commission promotes competition among private health insurers. Beginning in July 2016, the Australian eHealth Commission will take over responsibility from the National eHealth Transition Authority for matters relating to electronic health data.

State governments operate their own departments of health, and have devolved management of hospitals to the LHNs. The LHNs are responsible for working collaboratively with PHNs. There are patient–consumer organizations and groups operating at the national and state level.

What are the major strategies to ensure quality of care?

The overarching strategy to ensure quality of care is captured in the National Healthcare Agreement of the COAG (2012). The agreement sets out the common objective of Australian governments in providing health care—improving outcomes for all and the sustainability of the system—and the performance indicators and benchmarks on which progress is assessed. It also sets out national-priority policy directions, programs, and areas for reform, such as major chronic diseases and their risk factors. Indicators and benchmarks in the agreement address issues of quality from primary to tertiary care and include disease-specific targets of high priority, as well as general benchmarks.

The Australian Commission on Safety and Quality in Health Care (ACSQH) is the main body responsible for safety and quality improvement in health care. The ACSQH has developed service standards that have been endorsed by health ministers (DH, Portfolio Budget Statement 2015–16). These include standards for conducting patient surveys, which must be met by hospitals and day surgery centers for accreditation. The ABS, the national government statistical body, also undertakes an annual patient experience survey.

The Australian Council on Healthcare Standards is the (nongovernment) agency authorized to accredit provider institutions. States license and register private hospitals and the health workforce, legislate on the operation of public hospitals, and work collaboratively through a National Registration and Accreditation Scheme facilitating workforce mobility across jurisdictions while maintaining patient protections.

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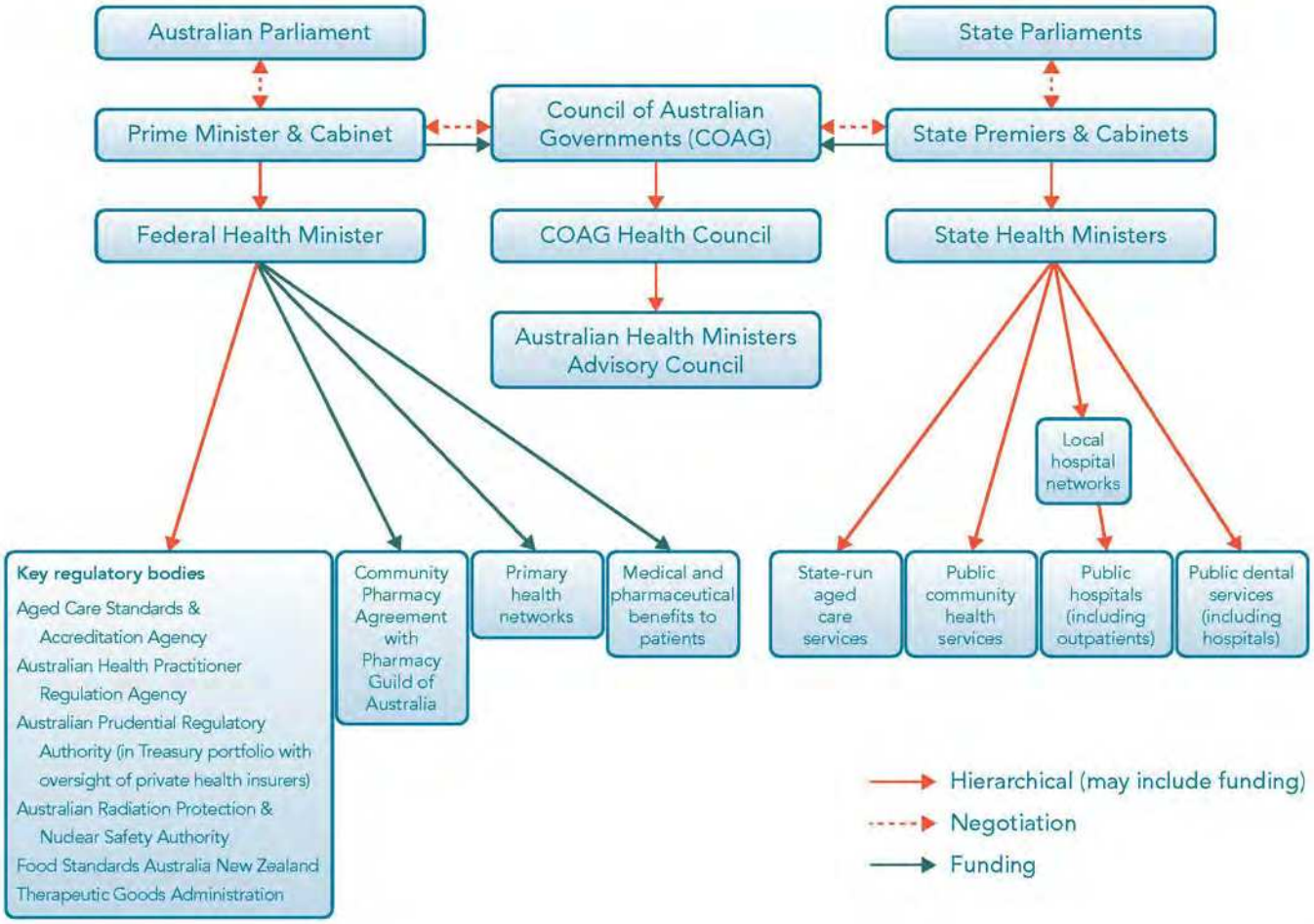
Organization of the Health System in Australia



Source: L. Glover, 2015.

The Royal Australian College of General Practitioners has responsibility for accrediting GPs. The MBS includes financial incentives such as the PIP, and approximately 85 percent of GPs are accredited. To be eligible for government subsidies, aged care services must be accredited by the government-owned Aged Care Standards and Accreditation Agency.

There are a number of disease and device registries. Government-funded registries are housed in universities and nongovernmental organizations, as well as within state governments. ACSQH has developed a national framework to support consistent registries.

The National Health Performance Authority reports on the comparable performance of LHNs, public and private hospitals, and other key health service providers. The reporting framework was agreed to by the COAG, and includes measures of equity, effectiveness, and efficiency.

The federal government has regulatory oversight of quarantine, blood supply, pharmaceuticals, and therapeutic goods and appliances (AIHW, 2014). In addition, there are a number of national bodies who promote quality and safety of care through evidence-based clinical guidelines and best-practice advice. They include the National Health and Medical Research Council and Cancer Australia.

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What is being done to reduce disparities?

The most prominent disparities in health outcomes are between the Aboriginal and Torres Strait Islander population and the rest of Australia's population; these are widely acknowledged as unacceptable. In 2008, the COAG agreed to a target date of 2031 for closing the gap in life expectancy. Its strategy goes beyond health care, seeking to address disparities in other areas such as education and housing. The Prime Minister makes an annual statement to Parliament on progress toward closing the gap.

Disparities between major urban centers and rural and remote regions and across socioeconomic groups are also major challenges. The federal government provides incentives to encourage GPs and other health workers to work in rural and remote areas, where it can be very difficult to attract a sufficient number of practitioners. This challenge is also addressed to an extent through the use of telemedicine. Since 1999, the Australian Government has funded the Public Health Information Development Unit (www.publichealth.gov.au) for the purpose of publishing small-area data showing disparities in access to health services and health outcomes on a geographic and socioeconomic basis.

What is being done to promote delivery system integration and care coordination?

Approaches to improving integration and care coordination include the PIP, which provides a financial incentive to providers for the development of care plans for patients with certain conditions, such as asthma, diabetes, and mental health needs. The PHNs were established in July 2015 with the objective of improving coordinated care, as well as the efficiency and effectiveness of care for those at risk of poor health outcomes. These networks are funded through grants from the federal government and will work directly with primary care providers, health care specialists, and LHNs. Care also may be coordinated by Aboriginal health and community health services.

What is the status of electronic health records?

The National eHealth Transition Authority has been working to establish interoperable infrastructure to support communication across the health care system. A national e-health program based on personally controlled unique identifiers has commenced operation in Australia, and 2.5 million patients and nearly 8,000 providers have registered (DH, 2015a). The record supports prescription information, medical notes, referrals, and diagnostic imaging reports. Following a review, government is taking a number of steps to increase uptake by both patients and providers, which has been poor to date, by improving usability, clinical utility, governance, and operations. In addition, an opt-out approach will be tested to replace the current opt-in approach. The new Australian Commission for eHealth will begin oversight in July 2016, taking on the e-health roles of the Department of Health and the National eHealth Transition Authority. The current PIP eHealth Incentive, which aims to encourage GPs to participate, also will be reviewed for potential improvements.

How are costs contained?

The major drivers of cost growth are the MBS and PBS. Government regularly considers opportunities to reduce spending growth in the MBS through its annual budget process and has established an expert panel to undertake a review of the entire schedule and report by the end of 2016.

Government influences the cost of the PBS in making determinations about what pharmaceuticals to list on the scheme and in negotiating the price with suppliers. Government provides funds to pharmacies for dispensing medicines subsidized through the PBS and to support professional programs and the wholesale supply of medicines. This arrangement is through the current Community Pharmacy Agreement (the Community Pharmacy Agreements were instituted in 1991 and are subject to renegotiation every five years). The Sixth Community Pharmacy Agreement, which began in July 2015, supports AUD6.6 billion (USD4.3 billion) in savings through supply chain efficiencies (Ley, 2015).

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Hospital funding is set through policy decisions by the federal government, with states required to manage funding within their budgets.

Through the 2015–2016 budget, the federal government also consolidated the back-office functions of a number of its health agencies to generate AUD106 million (USD69 million) in savings. Beyond these measures, the major control is through the capacity constraints of the health system, such as workforce supply.

What major innovations and reforms have been introduced?

In 2015, the federal government announced a number of reforms to primary care, including implementation of the aforementioned PHNs and the MBS Review. In addition, the government has established the Primary Health Care Advisory Group to consider innovations to funding and service delivery for people with complex and chronic illness, including mental health. Together, these three reforms seek to ensure that primary care is being delivered efficiently and effectively and that Medicare is put on a sustainable funding trajectory. The group's advice, which was submitted to the government at the end of 2015, will consider how to best utilize the PHNs.

The government is also reforming care for the aging. In addition to the implementation of the Commonwealth Home Support program outlined above, a new funding model is pursued whereby allocations will be made directly to consumers based on their care needs instead of directly to service providers, affording them greater choice in providers and stimulating provider competition. This reform will take effect in February 2017.

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The Canadian Health Care System, 2015

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What is the role of government?

Provinces and territories in Canada have primary responsibility for organizing and delivering health services and supervising providers. Many have established regional health authorities that plan and deliver publicly funded services locally. Generally, those authorities are responsible for the funding and delivery of hospital, community, and long-term care, as well as mental and public health services. Nearly all health care providers are private. The federal government cofinances provincial and territorial programs, which must adhere to the five underlying principles of the Canada Health Act—the law that sets standards for medically necessary hospital, diagnostic, and physician services. These principles state that each provincial health care insurance plan needs to be: 1) publicly administered; 2) comprehensive in coverage; 3) universal; 4) portable across provinces; and 5) accessible (i.e., without user fees).

The federal government also regulates the safety and efficacy of medical devices, pharmaceuticals, and natural health products; funds health research; administers a range of services for certain populations, including First Nations, Inuit, Métis, and inmates in federal penitentiaries; and administers several public health functions.

Who is covered and how is insurance financed?

Publicly financed health care: Total and public health expenditures were forecast to account for an estimated 10.9 percent and 8.0 percent of GDP, respectively, in 2015; by that measure, 70.7 percent of total health spending comes from public sources (Canadian Institute for Health Information, 2015a). The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents according to their own residency requirements (Health Canada, 2013a). Temporary legal visitors, undocumented immigrants (including denied refugee claimants), those who stay in Canada beyond the duration of a legal permit, and those who enter the country "illegally," are not covered by any federal or provincial program, although provinces and territories provide some limited services.

The main funding sources are general provincial and territorial spending, which was forecast to constitute 93 percent of public health spending in 2015 (Canadian Institute for Health Information, 2015a). The federal government contributes cash funding to the provinces and territories on a per capita basis through the Canada Health Transfer, which totaled CAD34 billion (USD27 billion) in 2015–2016, accounting for an estimated 24 percent of total provincial and territorial health expenditures (Canadian Institute for Health Information, 2015a; Government of Canada, 2015a).[1]

Privately financed health care: Private insurance, held by about two-thirds of Canadians, covers services excluded from public reimbursement, such as vision and dental care, prescription drugs, rehabilitation services, home care, and private rooms in hospitals. In 2013, approximately 90 percent of premiums for private health plans were paid through group contracts with employers, unions, or other organizations (Canadian Life and Health Insurance Association, 2014). In 2015, private health insurance accounted for approximately 12 percent of total health spending (Canadian Institute for Health Information, 2015a). The majority of insurers are for-profit.

[1] Please note that, throughout this profile, all figures in USD were converted from CAD at a rate of about CAD1.26 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Canada.

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What is covered?

Services: To qualify for federal financial contributions under the Canada Health Transfer, provincial and territorial insurance plans must provide first-dollar coverage of medically necessary physician, diagnostic, and hospital services (including inpatient prescription drugs) for all eligible residents. There is no nationally defined statutory benefits package; most public coverage decisions are made by provincial and territorial governments in conjunction with the medical profession. Provincial and territorial governments provide varying levels of additional benefits, such as outpatient prescription drugs, nonphysician mental health care, vision care, dental care, home health care, and hospice care. They also provide public health and prevention services (including immunizations) as part of their public programs.

Cost-sharing and out-of-pocket spending: There is no cost-sharing for publicly insured physician, diagnostic, and hospital services. All prescription drugs provided in hospitals are covered publicly, with outpatient coverage varying by province or territory. Physicians are not allowed to charge patients prices above the negotiated fee schedule. In 2012, out-of-pocket payments represented about 14.2 percent of total health spending (Canadian Institute for Health Information, 2015a), going mainly toward prescription drugs (21%), nonhospital institutions (mainly long-term care homes) (22%), dental care (16%), vision care (9%), and over-the-counter medications (10%) (Canadian Institute for Health Information, 2015a).

Safety net: Cost-sharing exemptions for noninsured services such as prescription drugs vary among provinces and territories, and there are no caps on out-of-pocket spending. For example, the prescription drug program in Ontario exempts low-income seniors and social assistance recipients from all cost-sharing except a CAD2.00 (USD1.60) copayment, which is often waived by pharmacies. Low income is defined as annual household income of less than CAD16,018 (about USD12,700) for single people and less than CAD24,175 (USD19,168) for couples.

There are no caps on out-of-pocket spending. However, the federal Medical Expense Tax Credit supports tax credits for individuals whose medical expenses, for themselves or their dependents, are significant (above 3% of income). A disability tax credit and an attendant care expense deduction also provide relief to individuals (or their dependents) who have prolonged mental or physical impairments, and to those who incur expenses for care that is needed to allow them to work.

How is the delivery system organized and financed?

Primary care: In 2014, about half of all practicing physicians (2.24 per 1,000 population) were general practitioners, or GPs (1.14 per 1,000 population) and half were specialists (1.10 per 1,000 population) (Canadian Institute for Health Information, 2015b). Primary care physicians act largely as gatekeepers, and many provinces pay lower fees to specialists for nonreferred consultations. Most physicians are self-employed in private practices and paid fee-for-service, although there has been a movement toward group practice and alternative forms of payment, such as capitation. In 2013–2014, fee-for-service payments made up 45 percent of payments to GPs in Ontario, compared with 67 percent in Quebec and 84 percent in British Columbia (Canadian Institute for Health Information, 2015c). In 2014, 46 percent of GPs reported to work in a group practice, 19 percent in an interprofessional practice, and 15 percent in a solo practice (National Physician Survey, 2014).

In some provinces, such as Ontario, some new primary care teams paid partly by capitation must require patients to register to receive those partial payments; otherwise, registration is not required. Clinical fee-for-service payments to primary care physicians in Canada averaged CAD249,154 (USD197,550) in 2013–2014 (Canadian Institute for Health Information, 2015c); these do not account for alternative payments and nonclinical payments. It has been estimated that the average payment, including alternative payments, for primary care physicians in Ontario is 21 percent higher than for fee-for-service alone (Henry et al., 2012).

In several provinces, networks of GPs work together and share resources. For instance, Primary Care Networks in Alberta, My Health Teams in Manitoba, and Family Health Teams in Ontario support interdisciplinary health professionals (e.g., nurses, pharmacists, and dietitians). In Ontario, the minimum size of practice for physicians in alternative payment models (not fee-for-service) is three (Sweetman and Buckley, 2014). In Family Health

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Teams, the average practice size is approximately 10 physicians, and ranges from seven to 14 physicians in other models (Rudoler et al., 2015). In Ontario, team composition varies among practices, and interdisciplinary providers are generally salaried employees of the practice.

Patients have free choice of primary care doctor, although in some areas choices are restricted owing to limited supply.

Provincial and territorial ministries of health negotiate physician fee schedules (for primary and specialist care) with provincial and territorial medical associations. In some provinces, such as British Columbia and Ontario, payment incentives have been linked to performance, and also are used to encourage the provision of a number of services including, but not limited to, delivering "guideline-based" care for specified chronic conditions, offering preventive services, developing care plans for patients with complex needs, and registering complex or vulnerable patients.

Outpatient specialist care: The majority of specialist care is provided in hospitals, although there is a trend toward providing services in private nonhospital facilities. Specialists are mostly self-employed and paid fee-for-service. Specialists in Canada received an average of CAD379,051 (USD300,545) annually in clinical fee-for-service payments in 2013–14 (Canadian Institute for Health Information, 2015c). In most provinces, specialists have the same fee schedule as primary care physicians. In 2014, 65 percent of specialists reported to work in a hospital, compared with 24 percent in a private office or clinic (National Physician Survey, 2014). Patients can choose, and have direct access to, a specialist, but it is common for GPs to refer patients to specialty care. Specialists who work in the public system are not permitted to receive payment from private patients for publicly insured services. There are few formal multispecialty clinics, although in some provinces, such as Ontario, there are informal, or virtual, networks of specialists that share patients and information (Stukel et al., 2013).

Administrative mechanisms for paying primary care doctors and specialists: The majority of physicians and specialists bill provincial governments directly, although some are paid a salary by a hospital or facility. There are no direct payments from patients to physicians; there is no cost-sharing, although patients may be required to pay for services that are not medically necessary—for example, physician letters sent to employers when employees are ill.

After-hours care: After-hours care is provided generally by physician-led (and mainly privately owned) walk-in clinics and hospital emergency rooms. In most provinces and regions, a free telephone service ("telehealth") is available 24 hours a day for health advice from a registered nurse. Traditionally, primary care physicians were not required to provide after-hours care, although many of the government-enabled group practice arrangements have requirements or financial incentives for providing after-hours care to registered patients. For example, in Ontario, physicians practicing in non-fee-for-service models have to provide sessions during some evenings and weekends. In some models, this amounts to a single three-hour session per week per physician in the group, up to five sessions per week (MOHLTC, 2009). These physicians are paid a 30 percent bonus for primary care services provided during evenings, weekends, and holidays (MOHLTC, 2011). Manitoba has implemented QuickCare clinics, staffed by nurses and nurse practitioners, to meet health care needs after hours (Government of Manitoba, 2015).

The 2012 Commonwealth Fund International Survey of Primary Care Doctors found that only 46 percent of physician practices in Canada had arrangements for patients to see a doctor or nurse after hours, with the highest rate in Ontario, at 67 percent (Health Council of Canada, 2013). The same survey found that only 30 percent of physicians received notification of hospital emergency department visits by their patients, and only about a quarter received a full report on specialist consultations.

Hospitals: Hospitals are a mix of public and private, predominantly not-for-profit, organizations, often managed locally by regional authorities or hospital boards representing the community. In provinces with regional health authorities, many hospitals are publicly owned (Marchildon, 2013), whereas in other provinces, such as Ontario, they are predominantly private nonprofit corporations. There are no data on the number of private for-profit clinics (which are mostly diagnostic and surgical). In Ontario, as of May 2014, the government was providing

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funding to 145 not-for-profit hospital corporations (with 224 different facilities and sites) and six private for-profit hospitals (Ontario Ministry of Health and Long-Term Care, 2014).

Hospitals in Canada generally operate under annual global budgets, negotiated with the provincial or territorial ministry of health or regional health authority. However, several provinces have considered introducing activity-based funding for hospitals, including Ontario, Alberta, and British Columbia (Sutherland et al., 2013, 2013a). Hospital-based physicians generally are not hospital employees and are paid fee-for-service directly.

Mental health care: There is universal coverage for physician-provided mental health care, alongside a fragmented system of allied services. Hospital mental health care is provided in specialty psychiatric hospitals and in general hospitals with adult mental health beds. The provinces and territories all provide a range of community mental health and addiction services including case management, community-based crisis response, and supported housing (Goering et al., 2000). Psychologists may work privately and are paid out-of-pocket or through private insurance, or under salary in publicly funded organizations. Mental health has not been formally integrated into primary care; any coordination or colocation of mental health services within primary care is unique to its particular practice. In Ontario, the government introduced an intersectoral mental health strategy in 2011 that aims to better integrate mental health care into primary care (Government of Ontario, 2011).

Long-term care and social supports: Long-term care and end-of-life care provided in nonhospital facilities and in the community are not considered insured services under the Canada Health Act. All provinces and territories fund services, but coverage varies among and within them. All provinces provide some nursing home care and some combination of case management and nursing care for home care clients, but there is considerable variation when it comes to other services, including medical equipment, supplies, and home support, and many jurisdictions require client contributions (OECD, 2011). About half of the provinces and territories provide some home care without means-testing, but access may depend both on assessed priority and on availability within capped budgets (Health Canada, 2013b).

Eligibility criteria for home and institutional long-term care services vary across provinces but generally include a needs assessment based on health status and functional impairment. Some provinces have established minimum residency periods as an eligibility condition for facility admission. Spending on nonhospital institutions, of which the majority are long-term care facilities, accounted for just over 10 percent of total health expenditure in 2013, with financing mostly from public sources (71%) (Canadian Institute for Health Information, 2015a).

A mix of private for-profit (41%), private not-for-profit (43%), and public facilities (13%) provide long-term care (Statistics Canada, 2011). Public funding of home care is provided either through provincial or territorial government contracts with agencies that deliver services (e.g., the Community Care Access Centres, in Ontario) or through government stipends to patients to purchase their own services (e.g., the "Choice in Support for Independent Living" program in British Columbia).

Provinces and territories are responsible for delivering palliative and end-of-life care in hospitals, where the majority of such costs occur. But many provide some coverage for services outside those settings, such as doctors, nurses, and drug coverage in hospices, in nursing facilities, and at home.

Support for informal caregivers (estimated to provide 66% to 84% of care to the elderly) varies by province and territory (Grignon and Bernier, 2012). In Ontario, for example, the Family Caregiver Leave Bill offers job protection to caregivers. There are also some federal programs, including the Family Caregiver Tax Credit and the Employment Insurance Compassionate Care Benefit (Canada Revenue Agency, 2014; Government of Canada, 2014).

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What are the key entities for health system governance?

Because of the high level of decentralization, provinces have primary jurisdiction over administration and governance of their health systems. The federal ministry of health, Health Canada, plays a role in promoting overall health, disease surveillance and control, food and drug safety, and medical device and technology review. The Public Health Agency of Canada is responsible for public health, emergency preparedness and response, and infectious and chronic disease control and prevention.

At the national level, several intergovernmental nonprofit organizations aim to improve governance by monitoring and reporting on health system performance; disseminating best practice in patient safety (the Canadian Patient Safety Institute); providing information to the public on health and health care and standardizing health data collection (the Canadian Institute for Health Information); and providing funding and support for provincial health information systems (Canada Health Infoway). The Canadian Agency for Drugs and Technologies in Health oversees the national health technology assessment process, which produces information about the clinical effectiveness, cost-effectiveness, and broader impact of drugs, medical technologies, and health systems. The Agency's Common Drug Review reviews the clinical effectiveness and cost-effectiveness of drugs and provides common, nonbinding formulary recommendations to the publicly funded provincial drug plans (except in Quebec) to support greater consistency in access and evidence-based resource allocation.

Nongovernmental organizations with important roles in system governance include professional organizations such as the Canadian Medical Association, provincial regulatory colleges, which are responsible for licensing professions and developing and enforcing standards of practice, and Accreditation Canada (see below). Most providers are self-governing under provincial and territorial law; they are registered with professional associations that ensure that education, training, and quality-of-care standards are met. The professional associations for physicians are also responsible for negotiating fee schedules with the provincial ministries of health. Most provinces have an ombudsperson providing patient advocacy.

What are the major strategies to ensure quality of care?

Since 2014, there have been no new national strategies initiated to ensure quality of care, although in the previous decade the Canada Health Accord provided for dedicated federal funding to provinces to achieve common goals in wait times, primary care, and home care. Some provinces have agencies responsible for producing health care system reports and for monitoring system performance, and many quality improvement initiatives take place at the provincial and territorial level. Examples include the Saskatchewan Health Quality Council, Health Quality Ontario, the British Columbia Patient Safety & Quality Council, and the New Brunswick Health Council.

The use of financial incentives to improve quality is limited. For example, since 2010, Ontario hospitals have been required to develop and report quality improvement plans, and executive compensation has been linked to the achievement of targets set out in these plans (Government of Ontario, 2010).

The federally funded Canadian Patient Safety Institute promotes best practices and develops strategies, standards, and tools. The Optimal Use Projects program, operated by the Canadian Agency for Drugs and Technologies in Health, provides recommendations (though not formal clinical guidelines) to providers and consumers in order to encourage the appropriate prescribing, purchasing, and use of medications. The Canadian Institute for Health Information produces regular reports on health system performance.

There is no system of professional revalidation for physicians in Canada, but each province has its own process of ensuring that physicians engage in lifelong learning, such as a requirement that they participate in a continuing education program, and undergo peer review. There is no information available on doctors' performance. Accreditation Canada—a not-for-profit organization—provides voluntary accreditation services to about 1,200 health care organizations across Canada, including regional health authorities, hospitals, long-term care facilities, and community organizations.

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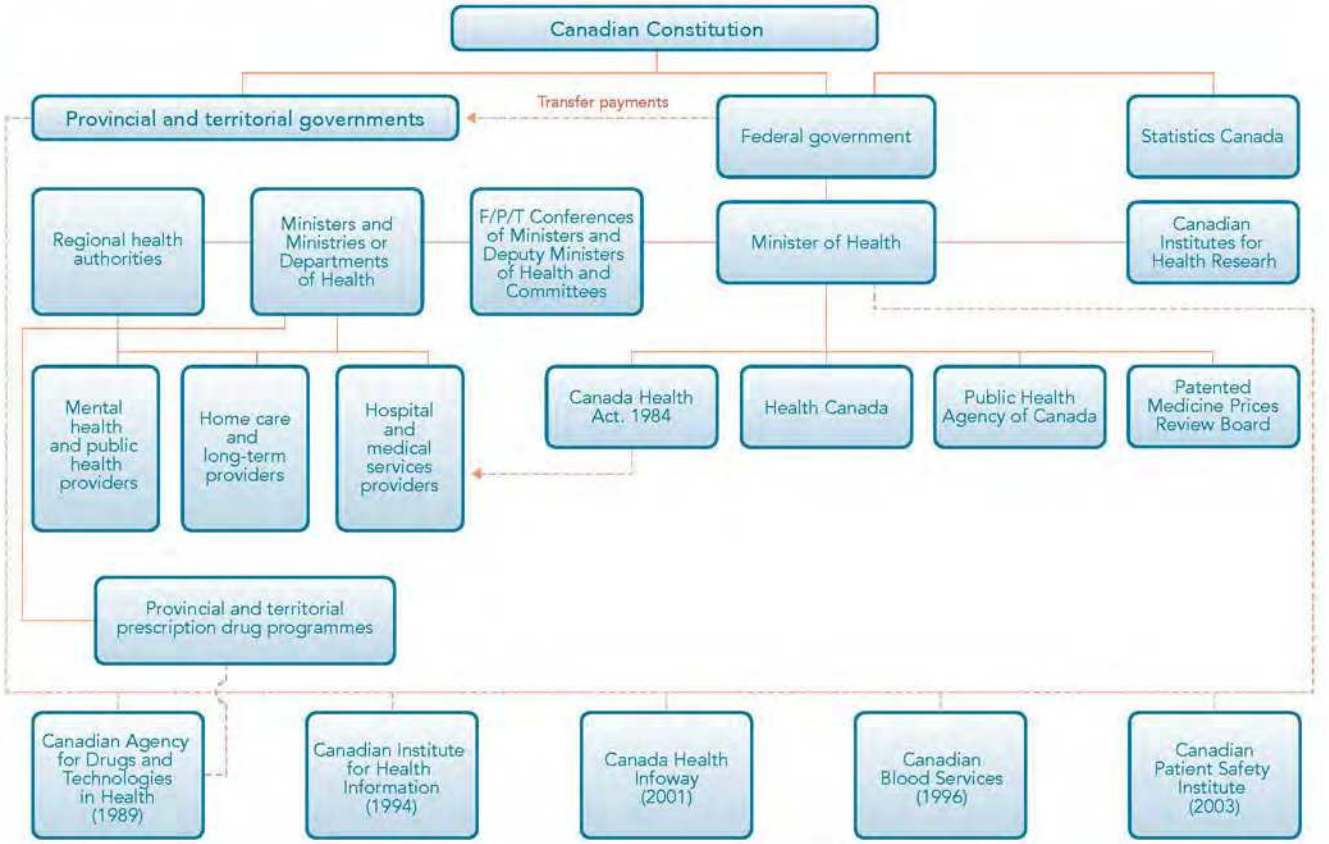
Organization of the Health System in Canada



Note: Solid lines represent direct relationships of accountability while dotted lines indicate more indirect or arm's length relationships.

Source: Adapted from G. P. Marchildon, "Canada: Health System Review," *Health Systems in Transition*, vol. 15, no. 1, 2013, p. 22.

Few formal disease registries exist, although many provincial cancer care systems maintain some type of patient registry. Provincial cancer registries feed data to the Canadian Cancer Registry, a national administrative survey that tracks cancer incidence. There is no national patient survey, although a standardized acute-care hospital inpatient survey developed by the Canadian Institute for Health Information has been implemented in several provinces. Each province has its own strategies and programs to address chronic disease (see below).

What is being done to reduce disparities?

By signing the *Rio Political Declaration on Social Determinants of Health*, Canada committed to reducing inequalities in health (Public Health Agency of Canada, 2011). Although no single body is responsible for addressing health disparities, several provincial or territorial governments have departments and agencies devoted to addressing population health and health inequities.

Aboriginal health is a concern for federal as well as provincial and territorial governments; recent federal initiatives include the Aboriginal Diabetes Initiative, the National Aboriginal Youth Suicide Prevention Strategy, and the Maternal Child Health Program. The Public Health Agency of Canada includes in its mandate reporting on health disparities, and the Canadian Institute for Health Information also reports on disparities in health care and health outcomes (Canadian Institute for Health Information, 2015d). However, no formal and periodic process exists to measure disparities.

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What is being done to promote delivery system integration and care coordination?

Provinces and territories have introduced several initiatives to improve integration and coordination of care for chronically ill patients with complex needs. These include Divisions of Family Practice (British Columbia) (Divisions of Family Practice, 2014), the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario). Also, Ontario has alternative community-based and multidisciplinary primary care models that are funded by the province and serve primarily vulnerable populations; these models include Community Health Centres and Aboriginal Health Access Centres. Also in Ontario, a pilot program that bundles payments across different providers is being expanded (from one to six communities) to improve coordination of care for patients as they transition from hospital to the community (Government of Ontario, 2015). As discussed above, some provinces also have implemented incentives to encourage physicians to provide guideline-based care for chronic disease. In Ontario, for example, Diabetes Education Programs (employing teams of diabetes education nurses and registered dieticians) support individuals and primary care physicians in providing guideline-based diabetes care (Government of Ontario, 2015a).

Each province determines its own structure for the coordination of health and social care services. In Ontario, for instance, Community Care Access Centres are also responsible for coordinating services for vulnerable populations, particularly the elderly and individuals with disabilities, including health and social care services (e.g., supportive housing and meal delivery programs). In Ontario, there is a single ministry responsible for health and long-term care, with funding devolving to the regional level.

What is the status of electronic health records?

Uptake of health information technologies has been slowly increasing in recent years. Provinces and territories are responsible for developing their electronic information systems, with support from Canada Health Infoway; however, there is no national strategy for implementing electronic health records and no national patient identifier. According to Canada Health Infoway, provinces have systems for collecting data electronically for the majority of their populations (Canada Health Infoway, 2014). Interoperability, however, is limited (Ogilvie and Eggleton, 2012). In 2014, 42 percent of GPs reported using exclusively electronic records to enter and retrieve patient clinical notes, and 38 percent used a combination of paper and electronic charts (National Physician Survey, 2014). In the same survey, 87 percent of GPs report that their patients are not able to access their personal health record for any function, and only 6 percent reported that patients can request appointments online.

How are costs contained?

Costs are controlled principally through single-payer purchasing, and increases in real spending mainly reflect government investment decisions or budgetary overruns. Cost-control measures include mandatory global budgets for hospitals and regional health authorities, negotiated fee schedules for providers, drug formularies, and resource restrictions vis-à-vis physicians and nurses (e.g., provincial quotas of students admitted annually) as well as restrictions on new investment in capital and technology. The national health technology assessment process is one of the mechanisms for containing the costs of new technologies (see above).

The federal Patented Medicine Prices Review Board, an independent, quasi-judicial body, regulates the introductory prices of new patented medications. This measure ensures that prices are not "excessive," on the basis of their "degree of innovation" and by comparison with prices of existing medicines in Canada and in seven other countries, including the United States and the United Kingdom. The board regulates "ex-factory" prices but does not have jurisdiction over wholesale or pharmacy prices, or over pharmacists' professional fees. However, prices of all patented drugs are reviewed regularly, and the board can intervene if price increases are deemed excessive. Since 2010, the Pan-Canadian Pricing Alliance also coordinates, across provinces, negotiations to reduce the prices of branded drugs. Jurisdiction over prices of generics and control over pricing and purchasing under public drug plans (and, in some cases, pricing under private plans) is held by provinces, leading to some interprovincial variation. "Choosing Wisely Canada" is a new publicly funded campaign that

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provides recommendations to governments, providers, and the public on reducing low-value care (Choosing Wisely Canada, 2015).

What major innovations and reforms have been introduced?

At the annual meeting of Canada's provincial premiers in July 2015, national health care priorities included pharmaceuticals, appropriateness of care, senior care, and dementia. There has not been a meeting between the first ministers of the federal and provincial governments on health care since 2009. In its 2015 election platform, the Liberal Party committed to a CAD3 billion (USD2.4 billion) investment in home care services and proposed a pan-Canadian collaboration to improve access to prescription medication (Liberal Party of Canada, 2015).

In 2015, the Canadian government expanded the National Anti-Drug Strategy to include prescription drug abuse. This strategy focuses on reducing the supply of and demand for illicit drugs (Government of Canada, 2015b). Also introduced in 2015 was the Protecting Canadians from Unsafe Drugs Act (Vanessa's Law), which strengthens regulation on therapeutic products to promote reporting of adverse reactions by health care institutions (Government of Canada, 2014).

Provincial health system governance: Several provinces have reformed or are in the process of reforming their health system governance structures, mostly in an attempt to achieve efficiencies and reduce costs. Quebec is merging 182 Health and Social Centres, which include hospitals, clinics, and long-term care facilities, into just 28 (Assemblée Nationale Québec, 2015). In April 2015, Nova Scotia passed legislation to consolidate 10 district health authorities into two: the Nova Scotia Health Authority and the IWK Health Centre. The two merged authorities will work together to plan and deliver primary care, community health services, and acute care across the province (Government of Nova Scotia, 2015). The 2015 Newfoundland and Labrador provincial budget announced the consolidation of administrative service for the health care system into one shared services organization. The regional health authorities will remain in place, while the shared services organization will provide them with support for human resources, information technology, telecommunications, marketing, communications, finance, and payroll (Government of Newfoundland Labrador, 2015). The government appointed an implementation team in August 2015.

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The Chinese Health Care System, 2015

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What is the role of government?

In China, the central government has overall responsibility for national health legislation, policy, and administration. It is guided by the principle that every citizen is entitled to receive basic health care services, with local governments—provinces, prefectures, cities, counties, and towns—responsible for providing them according to local circumstances. Health authorities include the National Health and Family Planning Commission and the local Health and Family Planning Commissions (or Bureaus of Health, if they have not been merged with local Family Planning Commissions), which have primary responsibility for organizing and delivering health care and supervising providers (mainly hospitals). Health authorities at the prefectures/city, county, and town levels have limited flexibility in carrying out provincial health policies.

Who is covered and how is insurance financed?

Generally, health insurance is publicly provided and financed by local governments.

Publicly financed health insurance: In 2013, China spent approximately 5.6 percent of its gross domestic product (CNY3,187B, or USD871B) on health care, with 30 percent financed by local governments and 36 percent by publicly financed health insurance, private health insurance, or social health donations (National Health and Family Planning Commission, 2014). There were three main types of publicly financed insurance: 1) urban employment-based basic insurance (launched in 1998); 2) urban resident basic insurance (launched in 2009); and 3) the new cooperative medical scheme for rural residents (launched in 2003).

Urban employment-based basic insurance is mainly financed from employee and employer payroll taxes, with minimal government funding. Participation is mandatory for employees in urban areas; the insured population was 274.2 million in 2013 (National Health and Family Planning Commission, 2014). Employees' nonemployed family members are not covered. Urban resident basic insurance, which is voluntary at the household level, covered 299 million self-employed individuals, children, students, and elderly adults in 2013. Both urban employment-based and urban resident insurance are administered by the Ministry of Human Resources and Social Security and run by local authorities. The new cooperative medical scheme, mainly administered by the National Health and Family Planning Commission and run by local authorities, is also voluntary at the household level and covered a rural population of 802 million in 2013, representing a coverage rate of 98.7 percent.

Urban resident basic insurance and the new cooperative medical scheme are mainly government financed. In regions where the economy is less developed, the central government provides the largest share of subsides, with provincial and prefectural governments providing the rest. In more-developed provinces, most government subsidies are locally provided (mainly provincial). Coverage of publicly financed health insurance is near-universal—exceeding 95 percent of the population since 2011 (Jiang and Ma, 2015). The few permanent foreign residents are entitled to the same coverage benefits as citizens. Undocumented immigrants (there are very few) and visitors are not covered by publicly financed health insurance.

[1] Please note that, throughout this profile, all figures in USD were converted from CNY at a rate of about CNY3.66 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for China.

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Private health insurance: Complementary private health insurance is purchased to cover deductibles, copayments, and other cost-sharing, as well as coverage gaps, in publicly financed health insurance, which serves as the primary coverage source for most people. Private coverage is provided mainly by for-profit companies. In 2014, total premiums collected amounted to CNY158.7B (USD43.4B), an increase of 45 percent compared to the prior year, and represents approximately 10 percent of total (public and private) health insurance spending (Zhao et al., 2015; Liu, 2015).

Purchased primarily by higher-income individuals and by employers for their workers, private insurance often enables people to receive better quality of care and higher reimbursement, as some health services are very expensive or not covered by public insurance. There are currently no statistics on the percentage of the population with private coverage, but the Chinese government is encouraging development of this market. Growth in private coverage has been rapid, with some foreign insurance companies recently entering the market.

What is covered?

Services: Publicly financed insurance covers primary, specialist, emergency department, hospital, and mental health care, as well as prescription drugs, and traditional medicine. A few dental services (e.g., tooth extraction, but not cleaning) and optometry services are covered, but mostly they are paid for completely out-of-pocket. Home care and hospice care are often not included either. Local health authorities define the benefits package. Preventive services such as immunization and disease screening are included in a separate public-health benefits package funded by central and local government; every citizen and migrant is entitled to these without copayments or deductibles. Coverage is person-specific; there are no family or household benefit arrangements.

Cost-sharing and out-of-pocket spending: Inpatient and outpatient care, including prescription drugs, is subject to different deductibles, copayments, and reimbursement ceilings. There are no annual caps on out-of-pocket spending. In 2013, out-of-pocket spending per capita was CNY2,327 (USD636) to CNY3,234 (USD886) and CNY1,274 (USD348) in urban and rural areas, respectively—representing about 34 percent of total health expenditures (National Health and Family Planning Commission, 2014).

Most out-of-pocket spending is for prescription drugs. Reimbursement ceilings are significantly lower for outpatient care than for inpatient care. For example, in 2013, ceilings were CNY3,000 (USD820) for outpatient care and CNY180,000 (USD49,180) for inpatient care in the rural new cooperative medical scheme in Beijing.

Provider networks are specific to the insurance scheme, normally at the prefecture-level for urban employment-based basic health insurance and urban resident basic health insurance (which may share the same network, but with different benefits) and at the county-level for new cooperative medical scheme. People can use out-of-network health services (even across provinces), but these have higher copayments. There are no universal cost-sharing arrangements, and each risk-pooling unit (network) has its own policies. Cost-sharing in primary care facilities (village clinics, rural township hospitals, and urban community hospitals) and secondary/tertiary hospitals is also different, with the lowest copayments in the former. Secondary and tertiary hospitals are accredited by the local health authorities based on their qualifications, and both provide primary care, outpatient specialists, and inpatient hospital care. Migrant populations face much higher cost-sharing and out-of-pocket spending, since they often use care out-of-network. Fee schedules for primary and secondary care are regulated by the local health authorities and the Bureaus of Commodity Prices, and it is unlawful to charge patients above the fee schedules.

Safety net: For individuals who are not able to afford individual premiums for publicly financed health insurance or out-of-pocket spending (which is not capped), a medical financial assistance program, funded by local governments and social donations, serves as safety net in both urban and rural areas. In Beijing, the individual poverty level in 2015 was defined as CNY670 (USD183) per month in rural areas and CNY710 (USD194) in urban areas; poverty levels for other provinces may be lower than Beijing. Medical financial assistance programs prioritize inpatient care expenses. Funds are mainly used to pay for individual deductibles, copayments, and

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medical spending exceeding annual caps, as well as individual premiums for publicly financed health insurance. In 2013, 63.6 million people (approximately 5% of the Chinese population) received such assistance for health insurance enrollment, and 21.3 million people (1.6% of the population) received funds for direct health expenses (China National Health and Family Planning Commission, 2014).

There are other financial assistance programs to help with unreimbursed emergency department expenses and other health expenses. Mostly these are funded by local governments.

How is the delivery system organized and financed?

Primary care: Primary care is delivered mainly through village doctors and health workers in rural clinics, general practitioners (GPs) in rural township and urban community hospitals, and secondary and tertiary hospitals. Village doctors, who are not licensed GPs, can work only in village clinics. In 2013, there were 1.08 million village doctors and health workers (National Health and Family Planning Commission, 2014). Although rural patients are encouraged to seek care in village clinics or township hospitals and urban patients in community hospitals—as such providers are associated with lower cost-sharing rates—residents can also see any GP in upper-level hospitals directly.

Registration with a GP is not required and, except for the very few areas that use GPs as gatekeepers, referrals are generally not necessary to see outpatient specialists. In 2013, China had 194,310 licensed and assistant GPs (including preventive medicine), representing only 8.5 percent of all licensed physicians and assistant physicians (National Health and Family Planning Commission, 2014). Except for village doctors and health workers in the village clinics, GPs rarely practice solo or through partnership but instead work in a hospital with nurses and nonphysician clinicians. Village clinics in rural areas receive technical support from township hospitals.

Fee schedules for primary care are regulated by local health authorities and the Bureaus of Commodity Prices. Village doctors and health workers in the village clinics receive income through reimbursement of public health services (e.g., immunizations and chronic disease screening) and clinical services, as well as through markups of prescription drugs and government subsidies. Incomes vary substantially by region.

GPs at hospitals receive a base salary along with activity-based payments (e.g., patient registration fees, surgeries performed). With fee-for-service still the dominant payment mechanism for hospitals (see below), hospital-based physicians have strong financial incentives to induce demand. It is estimated that wages constitute only one-quarter of physician incomes; the rest is thought to be derived from practice activities. In 2013, 48 percent of outpatient revenues and 39 percent of inpatient revenues were from prescription drugs provided to patients in tertiary hospitals (National Health and Family Planning Commission, 2014). Care coordination is generally not incentivized.

Outpatient specialist care: Outpatient specialists are employed by and usually work in hospitals, through which they obtain their practice licenses. Although practicing in multiple settings is being introduced in China, most specialists practice in one hospital only. They receive compensation in the form of base salary and activity-based payments from hospitals. Patients can usually see outpatient specialists without GP referral.

Administrative mechanisms for direct patient payments to providers: Patients pay deductibles and copayments to hospitals at the point of service. Hospitals directly bill insurers the covered payment at the same time if the payment mechanism is fee-for-service or a diagnosis-related group (DRG) system. Hospitals receive annual lump-sum payments under global budgets or capitation.

After-hours care: Because village doctors and health workers often live in the same community as patients, they voluntarily provide some after-hours care when needed. Rural township hospitals and urban secondary and tertiary hospitals have emergency rooms or departments (EDs) where both primary care doctors and specialists are available, minimizing need for walk-in after-hours care centers. In EDs, nurse triage is not required and there are few other restrictions, so people can simply walk in and register for care at any time. (Urban community hospitals often do not provide after-hours care, given the availability of secondary and tertiary hospitals.) ED use

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is not substantially more expensive than usual care for patients. Information on patients' emergency visits is not routinely sent to their primary care doctors.

Hospitals: Hospitals can be public or private, nonprofit or for-profit. Most township hospitals and community hospitals are public, but both public and private secondary and tertiary hospitals exist in urban areas. Rural township hospitals and urban community hospitals are often regarded as primary care facilities, similar to village clinics rather than 'true' hospitals. In 2013, there were 13,396 public hospitals and 11,313 private hospitals (excluding township hospitals and community hospitals), of which 17,269 were not-for-profit and 7,440 were for-profit (National Health and Family Planning Commission, 2014). In 2013, there were 487,802 public primary care facilities and 427,566 private village clinics (National Health and Family Planning Commission, 2014).

Hospitals are paid through a combination of out-of-pocket payments, health insurance compensation, and, in the case of public hospitals, government subsidies—the latter representing 13.5 percent of total revenue in 2013 (National Health and Family Planning Commission, 2014). A significant number of patients pay 100 percent out-of-pocket, because they receive out-of-network services. Although fee-for-service is dominant, DRGs, capitation, and global budgets are becoming more popular in selected areas. Local health authorities set fee schedules, and doctor salaries and other payments are included in hospital reimbursement.

Mental health care: Mental health care, including disease diagnosis, treatment, and rehabilitation services, is provided in special psychiatric hospitals and psychological departments of tertiary hospitals. Patients with mild illness are often treated at home or in the community; only severe mentally ill patients are treated in psychiatric hospitals. Both outpatient and inpatient mental health services are covered by insurance, with benefits subject to lower copayment rates. In 2013, there were 28 million mental health patient visits to special psychiatric hospitals, and on average one psychiatrist treated 4.6 patients per day (National Health and Family Planning Commission, 2014). Mental health is not integrated with primary care.

Long-term care and social supports: In accordance with Chinese tradition, long-term care is provided mainly by family members at home. There are very few formal long-term care providers. Family caregivers are not entitled to financial support or tax benefits, and long-term care insurance is virtually nonexistent; expenses for care in long-term care facilities are paid almost entirely out-of-pocket. Government may provide some subsidies to long-term care facilities. On average, conditions in long-term care facilities are poor, and there are long waiting lists for enrollment in high-end facilities. Formal long-term care facilities usually provide only housekeeping, meals, and basic services like transportation, but very few health care services. Some long-term care facilities may coordinate health care with local township or community hospitals, however. There were 4.94 million beds for aged and disabled people in 2013 (National Bureau of Statistics, 2014). Some hospice care is available, but it is normally not covered by health insurance (Chen, 2014).

What are the key entities for health system governance?

In 2013, the Ministry of Health and the National Population and Family Planning Commission were merged into the National Health and Family Planning Commission as the main agency for health controlled by the State Council (central government). The State Administration of Traditional Chinese Medicine is affiliated with the new Commission. The National People's Congress is responsible for health legislation. However, major health policies and reforms may be initiated by the State Council and the Central Committee of the Communist Party as well, and these are also regarded as law.

The National Development and Reform Commission, which has been heavily involved in the recent health care system reform, oversees health infrastructure plans and competition among health care providers. The Ministry of Finance provides funding to government health subsidies, health insurance contributions, and health system infrastructure. The Ministry of Human Resource and Social Security runs urban employment-based basic insurance and urban resident basic insurance. The China Food and Drug Administration is responsible for drug approvals and licenses, but health technology assessment or cost-effectiveness have not played a significant role yet. The China Center for Disease Control and Prevention is administrated by the National Health and

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Family Planning Commission, though it is not a government agency. The Chinese Academy of Medical Science, under the National Health and Family Planning Commission, is the national center for health research.

The National Health and Family Planning Commission directly owns some hospitals in Beijing, and national universities directly administrated by the Ministry of Education also own affiliated hospitals. Local government health agencies, usually the Bureau of Health or Health and Family Planning Commission in each province, may have a similar structure and often own provincial hospitals. Local governments (for prefectures, counties, and towns) may have departments of health and own hospitals directly. Centers for Disease Control and Prevention also exist in local areas and are administered by the local bureaus or departments of health. At the national level, the China Center for Disease Control and Prevention provides technical support to the local centers only.

Both national and local Health and Family Planning Commissions have comprehensive responsibilities for health quality and safety, cost control, provider fee schedules, health information technology, and clinical guidelines.

What are the major strategies to ensure quality of care?

The Department of Health Care Quality within the Bureau of Health Politics and Hospital Administration and overseen by the National Health and Family Planning Commission is responsible for quality of care at the national level. The National Health Service Survey is conducted every five years (the latest in 2013), and a report is published after each survey highlighting data on selected quality indicators.

Hospitals must obtain licenses from local health authorities for hospital accreditation. Physicians get their practice licenses through hospitals, and they have to renew their licenses after a certain period. Several national hospital rankings are available from third parties too, but there are no financial incentives for hospitals to meet quality targets (Dong et al., 2015).

Following release of the "Temporary Directing Principles of Clinical Pathway Management" by the former Ministry of Health in 2009, clinical pathways are now regulated nationally and used in a similar manner as clinical guidelines are in Western countries. Previously, pathways were created at the hospital, rather than national, level.

What is being done to reduce disparities?

There are still severe disparities in accessibility and quality of health care, although China has made significant improvements in the past decade. Income-related disparities in health care access were serious before the reform of the health insurance system more than 10 years ago, as most people did not have any coverage at all. Today, publicly financed insurance coverage is now nearly universal and there are safety nets for the poor (see above); as a result, income-related disparities have been reduced substantially.

Remaining disparities in access are mainly because of variation in insurance benefit packages, urban and rural factors, and income inequality. Urban employment-based basic insurance offers broader benefit packages than the other two insurance schemes. To improve benefit packages and reduce disparities, central and local governments intend to consolidate insurance schemes, an effort that has already been piloted in selected areas, such as Dongying City in Shandong Province and Jinhua City in Zhejiang Province. In addition, central and local government subsidies to urban resident basic insurance and the rural newly cooperative medical scheme have increased in recent years.

Most good hospitals (particularly tertiary hospitals) are located in urban areas, where there are better-qualified health professionals. Village doctors are often undertrained. To help bridge the urban–rural health care divide, the central government and local governments sponsor training for rural doctors in urban hospitals and require new medical graduates to work as residents in rural health facilities. Nevertheless, the China Health and Family Planning Statistical Yearbooks show that substantial disparities remain.

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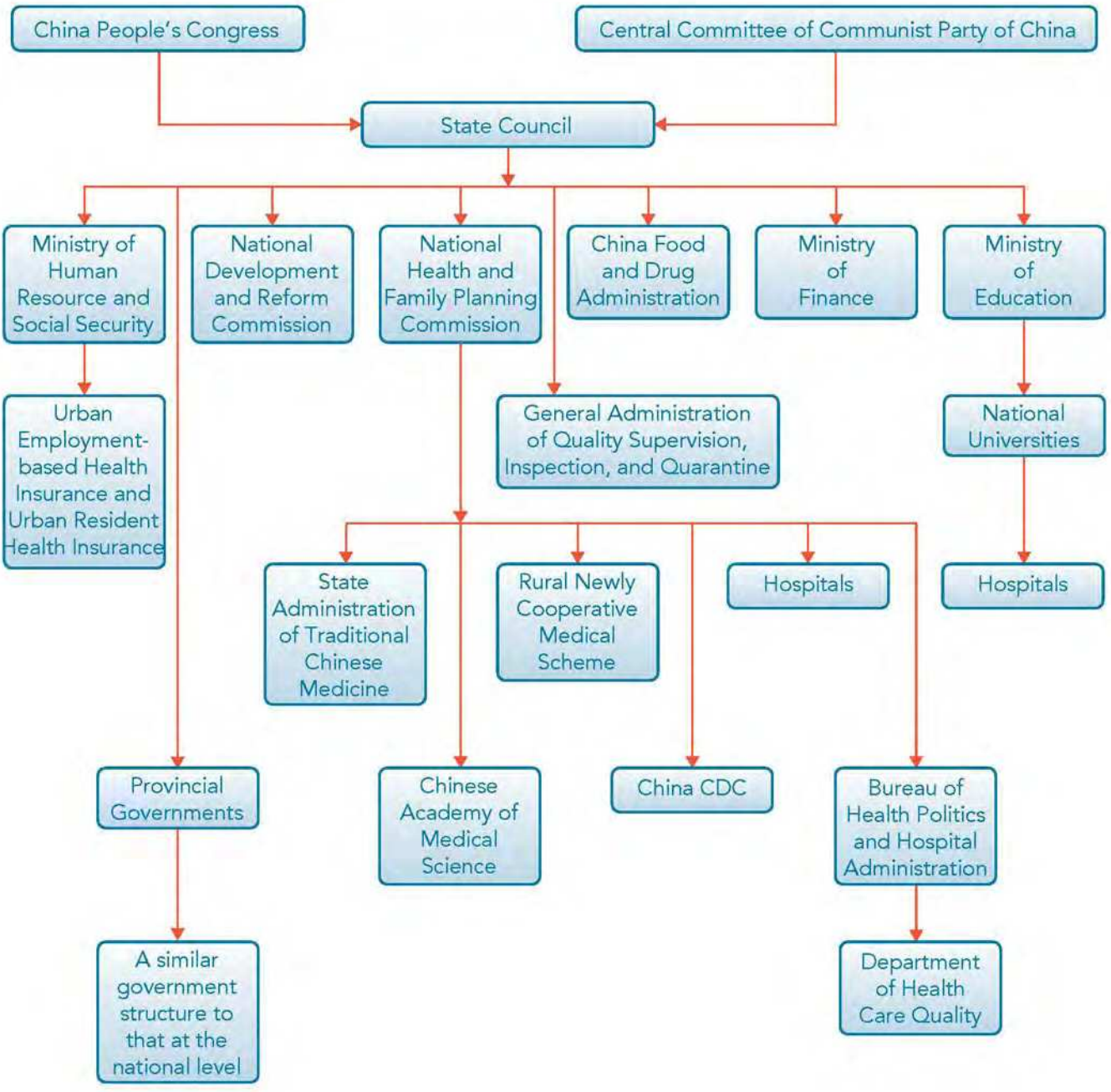
Organization of the Health System in China



Source: Hai Fang, Peking University, 2015.

What is being done to promote delivery system integration and care coordination?

Medical alliances are regional hospitals groups, often including one tertiary hospital and several secondary hospitals and primary care facilities, that provide access to primary care facilities for patients with minor health issues. The aim is to reduce the need for people to visit tertiary hospitals. At the same time, patients with serious health problems can be referred to tertiary hospitals easily and moved back to primary care facilities after their condition improves. It is hoped that this type of care coordination will meet demand for chronic

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disease care, improve health care quality, and contain rising costs. Hospitals in the same medical alliance use the same electronic health record system, and results of labs, images, and diagnoses can be shared easily within the alliance.

There are three main medical alliance models (Jiang et al., 2014). Hospitals in the Zhenjiang model have only one owner (usually the local bureau of health). Those in the Wuhan model do not belong to the same owner, but administration and finances are all handled by one tertiary hospital. Hospitals in the Shanghai model share management and technical skills only; ownership and financial responsibility are separate.

What is the status of electronic health records?

Nearly every health care provider has set up its own electronic health record (EHR) system. Within hospitals, EHRs are also linked to the health insurance systems for payment of claims with unique patient identifiers (citizenship ID). However, EHR systems vary significantly by hospital and are usually not integrated or interoperable. Patients often have to bring with them a printed health record if they would like to see doctors in different hospitals. Even if hospitals are owned by the same local bureau of health or universities in the same region, different EHR systems may be used. Patients generally do not use EHR systems for accessing information, appointment scheduling, secure messaging, prescription refills, or accessing doctors' notes.

How are costs contained?

Health expenditures have risen significantly in recent decades as a result of health insurance reform, population aging, economic development, and health technology advances. Health expenditures increased from CNY510 (USD139) per capita in 2003 to CNY3,234 (USD884) in 2013 (China National Health and Family Planning Commission, 2014). The key cost-containment strategy is reform of provider payment. Prior to the recent introduction of DRGs, global budgets, and capitation in 2009, fee-for-service was the main provider payment mechanism and consumer- and physician-induced demand increased costs significantly. Global budgets in particular have been used in many regions, since these are relatively easy for authorities to implement. As noted above, government encourages use of community and township hospitals over more expensive care provided in tertiary hospitals. Hospitals compete on the basis of quality, level of technology, and copayment rates.

In township, community, and county hospitals, a campaign of "zero markups" for prescription drugs was introduced in 2013 (see below).The National Development and Reform Commission places stringent supply constraints on new hospital buildings and hospital beds, and the National Health and Family Planning Commission controls the purchase of high-tech equipment such as MRI scanners.

What major innovations and reforms have been introduced?

Sales of prescription drugs have been a major revenue source for hospitals, which are allowed a 15 percent markup, and providers have strong financial incentives to induce demand for more and expensive drugs. Prices for services, on the other hand, are rather low, in accordance with traditional health practice in China. However, as of 2015, 3,077 public county hospitals and 446 public city hospitals were participating in a government-financed pilot program to eliminate markup of prescription drug prices. At the same time, 224 prefectures and cities in 21 provinces adjusted prices of health care services upward to reflect true costs. The zero-markup policy has been found to have significantly reduced total medical spending (Fu and Yang, 2013).

Another important health reform was the introduction in 2015 of special health insurance for severe diseases, such as cancers, kidney disease, and acute myocardial infarction (AMI), which supplements the regular publicly financed schemes. Severe-disease health insurance provides reimbursement beyond the rather low reimbursement ceilings. It is also mostly publicly financed, particularly for urban resident basic insurance and the rural new cooperative medical scheme, and administrated by local health authorities. However, private commercial health insurance companies, given their experience in providing complementary insurance, are heavily involved as well. By 2017, severe-disease insurance is expected to be available throughout China.

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The Danish Health Care System, 2015

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What is the role of government?

Universal access to health care is the underlying principle inscribed in Denmark's Health Law, which sets out the government's obligation to promote population health and prevent and treat illness, suffering, and functional limitations. Other core principles include high quality; easy and equal access to care; service integration; choice; transparency; access to information; and short waiting times for care. The law also assigns responsibility to regions and municipalities for delivering health services.

The national government sets the regulatory framework for health services and is in charge of general planning and supervision. Five administrative regions governed by democratically elected councils are responsible for the planning and delivery of specialized services, but also have tasks related to specialized social care and coordination. The regions own, manage, and finance hospitals and the majority of services delivered by general practitioners (GPs), office-based specialists, physiotherapists, dentists, and pharmacists. Municipalities are responsible for financing and delivering nursing home care, home nurses, health visitors, some dental services, school health services, home help, and treatment for drug and alcohol abuse. Municipalities are also responsible for general prevention and rehabilitation tasks; the regions are responsible for specialized rehabilitation.

Who is covered and how is insurance financed?

Publicly financed health care: Public expenditures in 2013 accounted for 84 percent of total health spending, representing 10.4 percent of GDP in 2013 (OECD, 2015a). It should be noted, however, that Danish cost reporting with regard to the "gray zone" of long-term care tends to include more activities (services) than reporting requirements do in many other member countries of the Organisation for Economic Co-operation and Development (OECD) (Søgaard 2014).

All registered Danish residents are automatically entitled to publicly financed health care, which is largely free at the point of use. In principle, undocumented immigrants and visitors are not covered, but a voluntary, privately funded initiative by Danish doctors, supported by the Danish Red Cross and Danish Refugee Aid, provides this population with access to care.

Health care is financed mainly through a national health tax, set at 8 percent of taxable income. Revenues are allocated to regions and municipalities, mostly as block grants, with amounts adjusted for demographic and social differences; these grants finance 77 percent of regional activities. A minor portion of state funding for regional and municipal services is activity-based or tied to specific priority areas, usually defined in the annual economic agreements between the national government and the municipalities or regions. The remaining 20 percent of financing for regional services comes from municipal activity-based payments, which are financed through a combination of local taxes and block grants.

Private health insurance: Complementary voluntary insurance, purchased on an individual basis, covers statutory copayments—mainly for pharmaceuticals and dental care—and services not fully covered by the state (e.g., physiotherapy). Some 2.2 million Danes have such coverage, which is provided almost exclusively by the not-for-profit organization Danmark (Sygeforsikringen "Danmark," 2014).

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In addition, nearly 1.5 million people hold supplementary insurance to gain expanded access to private providers (CEPOS, 2014). Policies are purchased mostly from among seven for-profit insurers and are provided mainly through private employers as a fringe benefit, although some public-sector employees are also covered. Students, pensioners, the unemployed, and others outside the job market are generally not covered by supplementary insurance.

Private expenditures accounted for nearly 16 percent of health care spending in 2013, and private insurance accounted for about 12 percent of total private expenditures (OECD, 2015a).

What is covered?

Services: Publicly financed health care covers all primary, specialist, hospital, and preventive care, as well as mental health and long-term care services. Dental services are fully covered for children under age 18. Outpatient prescription drugs, adult dental care, physiotherapy, and optometry services are subsidized. Home care and hospice care are organized and financed by the regions as described below.

Decisions about levels of service and new medical treatments are made by the regions, within a framework of national laws, agreements, guidelines, and standards. Municipalities decide on the service level for most other welfare services. There is no defined benefits package, but very few restrictions exist for treatments that are evidence-based and clinically proven.

Cost-sharing: There is no cost-sharing for hospital and primary care services. Cost-sharing is applied to dental care for those age 18 and older (coinsurance of 35% to 60% of total cost), outpatient prescriptions, and corrective lenses. Out-of-pocket payments represented 12.4 percent of total health expenditures in 2013 (OECD 2014), covering mostly outpatient drugs, corrective lenses, hearing aids, and doctor and dental care. Patients with outpatient drug expenses of more than 3,045 DKK (USD394) per year receive the highest reimbursement rate—85 percent.[1] Private specialists, hospitals, and dentists are free to set their own fees for patients not covered by public funding.

Safety net: There are cost-sharing caps for children, and municipalities provide means-tested social assistance to older people. If personal assets are DKK77,500 (USD10,217) or less, 85 percent of all prescription drug costs are covered. Chronically ill people with high drug usage and costs can apply for full reimbursement above an annual out-of-pocket ceiling of DKK3,775 (USD498). The terminally ill also can apply for full coverage of prescriptions. Municipalities may grant financial assistance to individuals certified as otherwise unable to pay for needed medicine.

How is the delivery system organized and financed?

Primary care: Around 22 percent of all doctors work in general practice. All general practitioners (GPs) are self-employed and paid by the regions via capitation (about 30% of income) and fee-for-service (70% of income). Rates are set through national agreements with the doctors' associations. Service-based fees are used as financial incentives to prioritize services. National fees are paid per consultation, whether for office visits, e-consults, or home visits. The average income for a GP was DKK1.1M (USD145,000) in 2011. The average salary for senior hospital doctors was DKK1M (USD132,000) (Danske Regioner, 2012).

The practice structure is gradually shifting from solo to group practices, typically consisting of two to four GPs and two to three nurses (Danske Regioner, 2007). The number of nurses employed has increased in the past decade; they are paid by the practice and have gradually assumed responsibility for such tasks as blood

[1] Please note that throughout this profile, all figures in USD were converted from DKK at a rate of about DKK7.59 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015b) for Denmark.

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sampling and vaccination. Colocation of various clinicians is also on the rise, with GPs, physiotherapists, and office-based specialists operating out of the same facilities but under separate management.

Anyone who chooses the "group 1" coverage option (98% of the population), under which GPs act as gatekeepers for secondary care, is required to register with a GP. People can register with any available local GP. "Group 2" coverage provides free choice of GP and access to practicing specialists without referral, though a copayment is required. Under both groups, access to hospitals requires referral.

Outpatient specialist care: Outpatient specialist care is delivered through hospital-based ambulatory clinics (fully integrated and funded, as are other public hospital services) or by self-employed specialists in privately owned facilities. Private self-employed specialists can be full-time or part-time; full-timers may not have other full-time jobs. Part-timers also may work in the hospital sector, subject to codes of conduct, with their activity level monitored and their incomes limited by the regions. Practices may be colocated but normally do not operate in formal multispecialty groups.

Services from self-employed private providers are paid by the regions on a fee-for-service basis for referred public patients. Fees are set through negotiations with the regions and are based on regional priorities and resource assessments. Private specialists and hospitals also receive patients paying out-of-pocket or covered by voluntary insurance. As a result of legislation initially introduced in 2013 guaranteeing patients the right to diagnostic assessment within 30 days of referral, private practitioners also may receive patients referred from public-sector providers; they are paid for these services through specific agreements with the regions.

Patients have a choice of private outpatient specialists upon referral (group 1) or without referral (group 2).

Administrative mechanisms for direct patient payments to providers: There is no out-of-pocket payment for medical services for patients in group 1. Primary care doctors and specialists are paid directly by the regions when registering provision of services electronically. Group 2 patients make a copayment to supplement the automatic payment (Strandberg-Larsen et al., 2007).

After-hours care: After-hours care is organized by the regions, mainly by agreement with GPs on a collective basis. The Copenhagen region employs staff including specialized nurses, who do the initial screening of calls. GPs can volunteer to take on more or less responsibility within this scheme, and receive a higher rate of payment for after-hours than for normal care. Capitation does not apply to after-hours care. The first line of contact is a regional telephone service, with a GP (or a nurse, in the Copenhagen region) deciding whether to refer the patient for a home visit or to an after-hours clinic, which is usually colocated with a hospital emergency department. Information on patient visits is sent routinely to GPs. There are walk-in emergency units in larger hospitals.

Hospitals: Approximately 97 percent of hospital beds are publicly owned. Regions decide on budgeting mechanisms, generally using a combination of fixed-budget and activity-based funding based on diagnosis-related groups (DRGs), where the fixed budget makes up the bulk of the funding (although significant fluctuations occur among specialties and hospitals). DRG rates are calculated by the Ministry of Health at the national level based on average costs. Activity-based funding is usually combined with target levels of activity and declining rates of payment to control expenditure. This strategy succeeded in increasing activity and productivity by an average of 5 percent annually from 2009 to 2011 and by 1.4 percent from 2011 to 2012 (Danske Regioner, 2015). Bundled payments are not yet used extensively. Hospital physicians are salaried and employed by regional hospitals, which bear the attendant costs, as are other health care professionals in hospitals and in most municipal health services. Patients can choose among public hospitals upon referral, and payment follows the patient to the receiving hospital if it is located in another region. Physicians at public hospitals are not allowed to see private patients within the hospital.

Mental health care: There is no cost-sharing for inpatient psychiatric care, but there is some cost-sharing (which may be covered by voluntary health insurance) for psychologists in private practice. Some general practitioners offer specific therapeutic consultations, but their main role is early detection and referral.

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Social psychiatry and care are a responsibility of the municipalities, which can choose to contract with a combination of private and public service providers, but most providers are public and salaried. A right to diagnostic assessment for psychiatry within one month of referral was introduced in 2014. Treatment must be commenced within two months for less serious conditions and one month for more serious conditions. There are walk-in units for acute psychiatric care in all regions.

Long-term care: Responsibility for chronic care is shared between regional hospitals, general practitioners, and providers of municipal institutional and home-based services. Hospital-based ambulatory chronic care is financed in the same way as other hospital services. Long-term care outside of hospitals is needs-based, and is organized and funded by municipalities. Most municipal long-term care is provided at home, in line with a policy initiative to allow people to remain at home as long as possible. Home nursing is fully funded after medical referral. Permanent home care is free of charge, while temporary home care can be subject to cost-sharing if the recipient's income is above DKK143,300 (USD18,890) for single individuals and DKK215,300 (USD28,380) for couples (Frederiksberg Kommune, 2015). Municipalities are obliged to organize markets with open access for both public and private providers of home care, and patients may choose between public or private providers. While this functions relatively well in most municipalities, it has been difficult to attract private providers to remote areas. A considerable number of the elderly choose private providers. Some municipalities also have contracted with private institutions for institutional care of older people, but more than 90 percent of residential care institutions (nursing homes) remain public.

Providers are paid directly by municipalities, and no cash benefits are paid to patients. Public providers are employed by the municipalities. For staying in residential care institutions, patients pay according to the facility's costs plus 10 percent of their income (20% of income above DKK188,700, or USD24,880), as well as heating and electricity charges (Rudersdal Kommune, 2015).

Relatives of seriously ill individuals may take paid leaves of absence from their jobs for up to nine months. These can be incremental and may be divided among several relatives. A similar scheme exists for relatives of terminally ill patients who no longer receive treatment.

Hospices, which may be public or private, are organized by regions and are funded by regions and municipalities. There is free choice of hospice upon referral.

What are the key entities for health system governance?

The general regulation, planning, and supervision of health services, including cost control mechanisms, take place at the national level through the Ministry of Health and the Danish Health Authority, Danish Medicines Agency, and Danish Patient Safety Authority. The national authorities are responsible for general supervision of health personnel and for development of quality management in line with national clinical guidelines and standards, usually in close collaboration with representatives from medical societies. These authorities also have important roles in planning the location of specialist services, approving regional hospital plans, and making mandatory "health agreements" between regions and municipalities to coordinate service delivery. Health technology assessments are developed at the regional level, while the national authorities do comparative effectiveness (productivity) studies that are published on a regular basis, allowing regions and hospital managers to benchmark performance of individual hospital departments (Danske Regioner, 2015).

Regions are in charge of defining and running hospital services and supervising and paying general practitioners and specialists. Municipalities have important roles in prevention, health promotion, and long-term care. Rates for general practitioners and practicing specialists are set through national agreements. Doctors' associations negotiate with a collective body of the regions, also including state representatives. Regions may enter into additional regional agreements for specific services.

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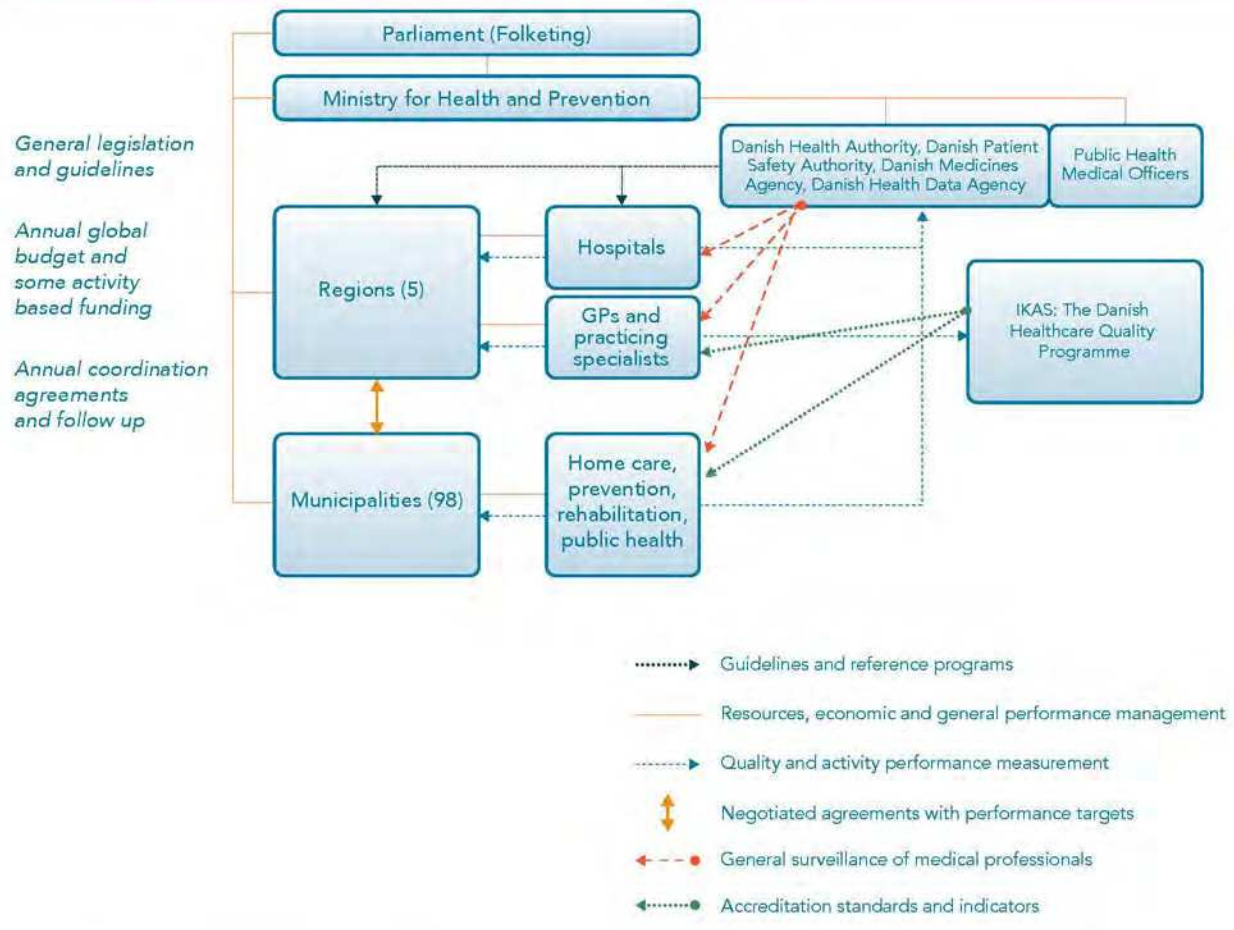
A national website (sundhed.dk) supports patient choice (see below). Organized patient groups engage in policymaking at the national, regional, and municipal levels. A patient ombudsman handles patient complaints and compensation claims, collects information about errors for systematic learning, and provides information about treatment abroad.

Aspects of care that are affected by regional benchmarking results, which are published online, include expenditures for administration; expenditures for support functions (washing and cleaning); organization and handling of free choice (of private provider); and psychiatry, obesity operations, selected medical treatments, knee operations, shoulder operations, heat treatment, and back operations (Danske Regioner, 2014c).

What are the major strategies to ensure quality of care?

The Danish Healthcare Quality Programme (DDKM), based on accreditation and a set of accreditation standards, was in operation at the hospital level through 2015 (DDKM). It is currently being replaced in hospitals with a new program featuring fewer standards and more emphasis on clinical and local dimensions (due partially to pressure from the medical profession). The DDKM continues to be rolled out in primary and municipal health care.

Organization of the Health System in Denmark



Source: K. Vrangbaek, University of Copenhagen, 2015.

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Quality data for a number of treatment areas are captured in clinical registries and published online for institutions, but not for individual health providers at the hospital level (sundhedskvalitet.dk). General quality and efficiency data also are published regularly in national level reports as a follow-up to national budget agreements between the state and the regions (Ministry of Health, 2013). Patient experiences are collected though biannual national, regional, and local surveys.

The Danish Health Authority has laid out standard treatment pathways, with priorities including chronic disease prevention and follow-up interventions. Pathways for 34 cancers have been in place since 2008, covering nearly all cancer patients. The authority monitors pathways and the speed at which patients are diagnosed and treated. DDKM standards enforce the use of pathway programs and national clinical guidelines for all major disease types. Regions develop more specific practice guidelines for hospitals and other organizations, based on general national recommendations. There are no explicit national economic incentives tied to quality, but several regions are experimenting with such schemes. In general, regions are obliged to take action in case of poor results, and may fire hospital managers or introduce other measures to support quality improvement. The Danish Health Authority can step in if entire regions fail to live up to standards.

The Danish Patient Safety Authority was created in 2015 when the former Danish Health and Medicines Authority was split into separate agencies. It receives anonymized reports of accidents and near-accidents that health care professionals at all levels are obliged to submit to regional authorities, which evaluate the incidents. The information is published in an annually updated database, with the intention of fostering learning rather than sanctioning.

What is being done to reduce disparities?

Regular reports are published on variations in health and health care access (Sundhedsstyrelsen, 2014). These have prompted the formulation of action plans, with initiatives including:

- higher taxes on tobacco
- targeted interventions to promote smoking cessation
- prohibition of the sale of strong alcohol to young people
- establishment of anti-alcohol policies in all educational institutions
- further encouragement of municipal disease prevention activities (e.g., through increased municipal cofinancing of hospitals, thus creating economic incentives for municipalities to keep citizens healthy and out of hospitals)
- improved psychiatric care
- a mapping of health profiles in all municipalities, to be used as a tool for targeting municipal disease prevention and health promotion activities.

The introduction of pathway descriptions (see above) is reported to have increased equity.

What is being done to promote delivery system integration and care coordination?

Current mandatory health agreements between municipalities and regions on coordination of care address a number of topics related to admission and discharge from hospitals, rehabilitation, prevention, psychiatric care, IT support systems, and formal progress targets. Agreements are formalized for municipal and regional councils at least once per four-year election term, generally take the form of shared standards for action in different phases of the patient journey in the system, and must be approved by the Danish Health Authority. The agreements are partially supported by IT systems with information that is shared between different

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caregivers. The performance of regions and municipalities in reaching the goals is measured by national indicators published online (esundhed.dk).

Regions and municipalities have implemented various measures to promote care integration. Examples include the use of outreach teams from hospitals doing follow-up home visits; training programs for nursing and care staff; establishment of municipal units located within hospitals to facilitate communication, particularly in regard to discharge; and the use of "general practitioner practice coordinators." Many coordination initiatives have a special emphasis on citizens with chronic care needs, multi-morbidity, or frailty due to aging or mental health conditions (Økonomi og Indenrigsministeriet, 2013). Municipalities are in charge of a range of services, including social care, elder care, and employment services; most are currently working on models for integrating these services better, such as through joint administration with shared budgets and formalized communication procedures.

Practices increasingly employ specialized nurses, and several municipalities and regions have provided financial support to set up multispecialty facilities, commonly called "health houses." Models vary, but often include GPs, practicing specialists, and physiotherapists, among others. GPs in medical homes are encouraged to function as coordinators of care for patients and to develop a comprehensive view of their patients' individual needs in terms of prevention and care. This principle is commonly accepted and is supported by the general national-level agreements between GPs and regions. GPs participate in various formal and informal network structures and are included in the health service agreements made between regions and municipalities to facilitate cooperation and improve patient pathways. All GPs use electronic information systems as a conduit for discharge letters, electronic referrals, and prescriptions.



What is the status of electronic health records?

Information technology (IT) is used at all levels of the health system as part of a national strategy supported by the National Agency for Health IT. Each region uses its own electronic patient record system for hospitals, with adherence to national standards for compatibility. Danish general practitioners were ranked first in an assessment of overall implementation of electronic health records in 2014 (HimSS Europe, 2014). All citizens in Denmark have a unique electronic personal identifier, which is used in all public registries, including health databases. A shared medical card—accessible by all relevant health professionals—has been implemented. It contains encoded information about each patient's prescriptions and medication use. General practitioners also have access to an online medical handbook with updated information on diagnosis and treatment recommendations. Attempts to develop national clinical databases to monitor quality in primary care (DataFangst) were aborted in 2015, as they were found to violate privacy rights and to endanger the trust between GPs and their patients.

Sundhed.dk is a national IT portal with differentiated access for health staff and the wider public. It provides general information on health and treatment options, and access to individuals' own medical records and history. For professionals, the site serves as an entry to medical handbooks, scientific articles, treatment guidelines, hospital waiting times, treatments offered, and patients' laboratory test results. The portal also provides access to available quality-of-care data for primary care clinics, all of which use IT for electronic records and communication with regions, hospitals, and pharmacies.



How are costs contained?

The overall framework for controlling health care expenditures is outlined in a "budget law," which sets budgets for regions and municipalities and specifies automatic sanctions if they are exceeded. The budget law is supplemented by annual agreements between regions, municipalities, and government that coordinate policy initiatives to control expenditures. These include direct controls of supply.

Block grants to regions are conditional on annual increases in productivity of 2 percent on the basis of diagnosis-related groups, and are withheld if productivity demands are not met. Even though the activity-based

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portion is small, it makes up regions' marginal income and presents a strong incentive (Danske Regioner, 2014). Furthermore, regions are under pressure to deliver good performance, as they can be reformed if they do not deliver.

At the regional level, hospital cost control includes a combination of global budgets and activity-related incentives (see above).

Inpatient pharmaceutical expenditure is controlled through national guidelines and clinical monitoring combined with collective purchasing. Two specific units have been established to evaluate and coordinate the introduction of expensive pharmaceutical products—the Council for the Use of Expensive Hospital Medicines (RADS) and the Coordinating Council for the First Use of Hospital Medicines (KRIS).

Policies to control outpatient pharmaceutical expenditure include generic substitution, prescribing guidelines, and assessment by the regions of deviations in prescribing behavior. Pharmaceutical companies report a monthly price list to the Danish Health Authority, and pharmacies are obliged to choose the cheapest alternative with the same active ingredient, unless a specific drug is prescribed. Patients may choose more expensive drugs, but they have to pay the difference.

Collective agreements with general practitioners and specialists include various types of clauses about rate reductions if overall expenditures exceed given levels. Regions also monitor the activity level of individual practices, and may intervene if they deviate significantly from the average.

Health technology assessment and cost-effectiveness information, produced nationally and regionally, is an integrated part of the decision-making process for new treatments and guidelines for professionals.

Regions may enter into contracts with private providers to deliver diagnostic and curative procedures. Prices for these services are negotiated between regions and private providers and can be lower than rates in the public sector.

These measures have been relatively successful in controlling expenditures and driving up activity levels. General productivity in the hospital sector increased almost 20 percent from 2008 to 2012, while maintaining high patient satisfaction and also reducing hospital standardized mortality rates (Danske Regioner, 2014b and 2014c).



What major innovations and reforms have been introduced?

A reorganization of the hospital infrastructure is currently under way. All five regions are in the process of closing or amalgamating small hospitals and building new hospitals, at a total cost of DKK40.0 billion (USD5.3 bilion). A central part of this process is the reorganization of acute care, with stronger prehospital services and larger specialized emergency departments with senior medical specialists at the front end.

The third generation of mandatory "health agreements" for coordination between municipalities and regions came into force in 2014. These agreements cover 2015–2018, and are based on a slightly revised format that resulted from a formal evaluation published in 2011.

Upscaling of municipal health services with "temporary care units" and various types of health centers is occurring, with colocation of municipal, private, and regional health providers. At the same time, municipalities are employing more nursing staff and public health specialists to provide more systematic services for population health (Rigsrevisionen, 2013).

A plan for reorganization of the central governance structure was decided on by the incoming government in August 2015, and was implemented in the fall of 2015. The reorganization will split the existing Health and Medicines Agency into four separate agencies, dealing with health, medicines, patient safety, and IT/data, to provide more clarity and improve the overall surveillance and accountability structure.

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The English Health Care System, 2015

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What is the role of government?

Responsibility for health legislation and general policy in England rests with Parliament, the Secretary of State for Health, and the Department of Health.[1] Under the Health Act (2006), the Secretary of State has a legal duty to promote a comprehensive health service, providing services free of charge, except for those with charges already in place. Rights for those eligible for National Health Service (NHS) care are summarized in the NHS Constitution; they include access to care without discrimination and within certain timeframes for some categories, such as emergency and planned hospital care (Department of Health, 2013b). The Department of Health provides stewardship for the overall health system, but day-to-day responsibility for running the NHS belongs to a separate public body, NHS England.

NHS England manages the NHS budget, oversees 209 local Clinical Commissioning Groups (CCGs), and ensures that the objectives set out in an annual mandate by the Secretary of State for Health are met, including both efficiency and health goals. Budgets for public health are held by local government authorities, which are required to establish "health and well-being boards" to improve coordination of local services and reduce health disparities.

Who is covered and how is insurance financed?

Publicly financed health care: In 2013, the U.K. spent 8.8 percent of GDP on health care, of which public expenditure, mainly on the NHS, accounted for 83.3 percent (Office of National Statistics, 2015). The majority of funding for the NHS comes from general taxation, and a smaller proportion from national insurance (a payroll tax). The NHS also receives income from copayments, people using NHS services as private patients, and some other minor sources.

Coverage is universal. All those "ordinarily resident" in England are automatically entitled to NHS care, largely free at the point of use, as are nonresidents with a European Health Insurance Card. For other people, such as non-European visitors or illegal immigrants, only treatment in an emergency department and for certain infectious diseases is free (Department of Health, 2013a).

Private health insurance: In 2012, 10.9 percent of the UK population had private voluntary health insurance (Nuffield Trust, 2013). The bulk of it was provided through employers (3.97 million policies) versus individual policies (0.97 million). Private insurance offers more rapid and convenient access to care, especially for elective hospital procedures, but most policies exclude mental health, maternity services, emergency care, and general practice (King's Fund, 2014). Data on private insurers are not freely available, but according to the Competition and Markets Authority (2014), four insurers account for 87.5 percent of the market, with small providers making up the rest.

What is covered?

Services: The precise scope of the NHS is not defined in statute or by legislation, and there is no absolute right for patients to receive a particular treatment. However, the statutory duty of the Secretary for Health is to ensure comprehensive coverage. In practice, the NHS provides or pays for preventive services, including screening,

[1] In cases where data for England are unavailable (e.g., financial or funding data), U.K. data are used instead.

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immunization, and vaccination programs; inpatient and outpatient hospital care; physician services; inpatient and outpatient drugs; clinically necessary dental care; some eye care; mental health care, including some care for those with learning disabilities; palliative care; some long-term care; rehabilitation, including physiotherapy (e.g., after-stroke care); and home visits by community-based nurses.

The volume and scope of these services are generally a matter for local decision-making, but the NHS Constitution also states that patients have a right to drugs or treatment approved in technology appraisals carried out by the National Institute of Health and Clinical Excellence (NICE), if recommended by their clinician (Department of Health, 2013b). For drugs or treatments that have not been appraised by NICE, the NHS Constitution states that CCGs shall make rational, evidence-based decisions (Department of Health, 2013b).[2] There is no routine reporting of how individual clinical commissioning groups make decisions, but a study of predecessor organizations found considerable variation (Nuffield Trust, 2011). There is also evidence of wide variations in access to some treatments, such as hip replacements (Royal College of Surgeons in England, 2014).

Cost-sharing and out-of-pocket spending: There are limited cost-sharing arrangements for publicly covered services. Out-of-pocket payments for general practice are limited to services that fall outside the purview of the NHS, including examinations for employment or insurance purposes and the provision of certificates for travel or insurance.

Outpatient prescription drugs are subject to a copayment (currently GBP8.20, or USD11.60, per prescription item in England); drugs prescribed in NHS hospitals are free. NHS dentistry services are subject to copayments of up to GBP222.50 (USD314.00) per course of treatment.[3] These charges are set nationally by the Department of Health. Out-of-pocket expenditure on health by households accounted for 11.9 percent of total expenditures in the U.K. in 2013 (Office for National Statistics, 2015). In 2013, the largest portion of out-of- pocket spending (34%) was for pharmaceuticals, followed by about 20 percent on medical appliances and equipment (Office for National Statistics, 2015).[4]

Safety net: People who are exempt from prescription drug copayments include children under age 16 and those 16 to 18 in school full time; people age 60 or older; people with low income; pregnant women and those who have had a baby in the past 12 months; and people with cancer, certain other long-term conditions, or certain disabilities. Patients who need large amounts of prescription drugs can buy prepayment certificates costing GBP29.10 (USD41.10) for a period of three months and GBP104 (USD147) for 12 months. Users incur no further charges for the duration of the certificate, regardless of how many prescriptions they need. In 2013, 90 percent of prescriptions in England were dispensed free of charge (Health and Social Care Information Centre, 2014a). Young people, students, pregnant and recently pregnant women, prisoners, and those with low incomes are not liable for dental copayments. Vision tests are free for young people, those over 60, and people with low incomes, and financial support to meet the cost of corrective lenses is available to young people and those with low incomes. Transportation costs to and from provider sites also are covered for people who qualify for the NHS Low Income Scheme.

How is the delivery system organized and financed?

Primary care: Primary care is delivered mainly through general practitioners (GPs), who act as gatekeepers for secondary care. In 2014, there were 36,920 general practitioners (full-time equivalents) in 7,875 practices, with an average of 7,171 patients per practice and 1,530 patients per GP. There were 40,443 hospital specialists and a further 53,786 hospital doctors in training (Health and Social Care Information Service, 2015a, 2015b). The number of solo practices is currently 843, while there are 3,589 practices with five or more GPs (Health

[2] A total of 533 appraisals were carried out between March 2000 and August 2014.

[3] Please note that, throughout this profile, all figures in USD were converted from GBP at a rate of GBP0.71 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for England.

[4] Including consumer spending on drugs and medical products not covered by the NHS, such as glasses, dental treatment, and spending on hospital and outpatient care.

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and Social Care Information Service, 2015a). General practices are normally patients' first point of contact, and people are required to register with a local practice of their choice; however, choice is effectively limited because many practices are full and do not accept new patients. In some areas, walk-in centers offer primary care services, for which registration is not required.

Most GPs (66%) are private contractors, and approximately 56 percent of practices operate under the national General Medical Services contracts, negotiated between the British Medical Association (representing doctors) and government. These provide payment using a mixture of capitation to cover essential services (representing about 60% of income), optional fee-for-service payments for additional services (e.g., vaccines for at-risk populations, about 15%), and an optional performance-related scheme (about 10%) (Health and Social Care Information Centre, 2015d). Capitation is adjusted for age and gender, local levels of morbidity and mortality, the number of patients in nursing and residential homes, patient list turnover, and a market-forces factor for staff costs as compared with those of other practices. Performance bonuses mainly relate to evidence-based clinical interventions and care coordination for chronic illnesses. The proportion of income from these bonuses will fall when the new 2014–15 contract is implemented, as the number of bonus-related services is reduced and funding rerouted into capitation.

The proportion of GPs employed in practices or on a salaried basis as locums (e.g., standing in when other GPs are unavailable) is increasing (currently around 20%). Most general practices employ other professionals such as nurses, who monitor patients for such things as blood pressure and provide minor treatments such as dressing wounds. The structure of general practice is changing, away from the single-handed "corner shops" and toward networked practices, including larger multipractice organizations using multidisciplinary teams of specialists, pharmacists, and social workers (King's Fund and Nuffield Trust, 2013). The average income for combined GPs (contracted and salaried) was GBP92,200 (USD130,200) before tax in 2013–2014 (Health and Social Care Information Service, 2015c).

Outpatient specialist care: Nearly all specialists are salaried employees of NHS hospitals, and CCGs pay hospitals for outpatient consultations at nationally determined rates. Specialists are free to engage in private practice within specially designated wards in NHS or in private hospitals; the most recent estimates (2006) were that 55 percent of doctors performed private work, a proportion that is declining as the earnings gap between public and private practice narrows (GHK Consulting and Office of Fair Trading, 2011). Patients are able to choose which hospital to visit, and the government has introduced the right to choose a particular specialist within a hospital (not yet fully implemented). Most outpatient specialist consultations are carried out in hospitals, although consultation may take place in general practices. Some GPs "with specialist interests" also offer specialist consultations, paid on a per-session or fee-for-service basis.

Administrative mechanisms for paying primary care doctors and specialists: The bulk of general practices are reimbursed monthly for the services they deliver on the basis of data extracted automatically from practices' electronic records. Some payments may require practices to enter data manually on the number of patients screened or treated for "enhanced services," which qualify for additional payments, such as diagnosis and support for patients with dementia. These data are collated and validated by NHS England.

After-hours care: GPs are no longer required personally to provide after-hours care to their patients (a small minority still do), but must ensure that adequate arrangements for its provision are in place. In practice, this means that CCGs contract mainly with GP cooperatives and private companies, both of which usually pay GPs on a per-session basis.

Serious emergencies are handled by hospital emergency departments. In some areas, less serious cases are seen in urgent care centers or minor-injury units, which are staffed in a variety of ways, and include nurse-led and GP-led centers. Telephone advice is available on a 24-hour basis through NHS 111 for those with an urgent but not life-threatening condition.

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Hospitals: Publicly owned hospitals are organized either as NHS trusts (currently 98) directly accountable to the Department of Health or as foundation trusts (currently 147) regulated by Monitor, an economic regulator of public and private providers. Foundation trusts enjoy greater freedom from central control, have easier access to capital funding, and are able to accumulate surpluses or run (temporary) deficits. Government wants all hospitals (including those providing mental health and ambulance services) to become foundation trusts in the near future.

Both trusts and foundation trust hospitals contract with local CCGs to provide services. They are reimbursed mainly at nationally determined diagnosis-related group (DRG) rates, which include medical staff costs and account for about 60 percent of income, with the remainder coming from activities not covered by DRGs, such as mental health, education, and research and training funds (Department of Health, 2013c). Responsibility for setting those rates is shared between NHS England and Monitor. In some areas, rates are not applied and payments are made for an overall service, such as emergency care. Also at the local level, fees for "years of care"—for example, for the total cost of the care a diabetic patient receives over 12 months—are being developed but as yet are not in widespread use. There is no cap on hospital incomes.

An estimated 548 private hospitals and between 500 and 600 private clinics in the U.K. offer a range of services, including treatments either unavailable in the NHS or subject to long waiting times, such as bariatric surgery and fertility treatment, but generally do not have emergency, trauma, or intensive-care facilities (Competition and Markets Authority, 2014). Private providers must be registered with the Care Quality Commission and with Monitor, but their charges to private patients are not regulated and there are no public subsidies. Although the volume of care purchased from private providers by the NHS has increased recently in areas outside of mental health, NHS use of private hospitals remains low—3.6 percent of overall spending by commissioners on hospital services in 2012–2013 (Nuffield Trust, 2014a).

Mental health care: Mental health care is an integral part of the NHS, which covers a full range of services. Less serious illnesses—mild depressive and anxiety disorders, for example—are usually treated by GPs. Those requiring more advanced treatment, including inpatient care, are treated by mental health or hospital trusts. Some of these services are provided by community-based staff. About a quarter of NHS-funded, hospital-based mental health services are provided by the private sector.

Over the past decade, policy has focused on increasing access to psychological therapies for mild to moderate mental health problems, though there can still be long waiting times. Policies to improve care of more severe conditions in the community have focused on outreach and early intervention, and there is an overarching aim to ensure "parity of esteem" between mental health and other kinds of health services. A review conducted in 2012 suggested that mental health services have been underfunded compared with treatment of physical illnesses (Centre for Economic Performance, 2012).

Long-term care and social supports: The NHS pays for some long-term care, such as for people with continuing medical or skilled-nursing needs, but payments in recent years have been substantially reduced. Most long-term care is provided by local authorities and the private sector. Local authorities are legally obliged to assess the needs of all people who request it, but, unlike NHS services, state-funded social care is not universal. With the exception of time-limited "reablement" services, some equipment and home modifications (in some areas), and information services, residential and home care are needs- and means-tested. Full state support for residential care, for example, is available only to those with less than GBP14,250 (USD20,123) in assets who also have high levels of need, with a sliding scale applied up to GBP23,250 (USD32,832). There is a national framework for assessing need, but local authorities are free to set eligibility thresholds for access to funds, which has become progressively more restricted (Nuffield Trust, 2014b).

Those eligible are liable for some copayments, with some people contributing almost all of their "assessed income," including pensions. Beneficiaries can receive personal budgets to purchase their own care but can also opt to have the local authority arrange it. Some additional allowances paid to users and carers are exempt from means testing, such as "attendance allowance," worth a maximum of GBP81.30 (USD115) a week.

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The 2014 Care Act aims to limit individuals' risk of catastrophic long-term care costs by imposing a cap on total out-of-pocket expenditure; however, this provision has been postponed until 2020 over cost concerns.

In 2009, the private sector provided 78 percent of residential care places for older people and the physically disabled in the U.K. (Laing and Buisson, 2013). The NHS provides end-of-life palliative care at patients' homes, in hospices (usually run by charitable organizations), in care homes, or in hospitals. Separate government funding is available for working-age people with disabilities.



What are the key entities for health system governance?

The Department of Health and the Secretary of State for Health are ultimately responsible for the health system as a whole. The Health and Social Care Act 2012 transferred important functions to NHS England, including overall budgetary control, supervision of CCGs, and, along with Monitor (described below), responsibility for setting DRG rates for provision of NHS services. NHS England also commissions some specialized low-volume services, national immunization and screening programs, and primary care. It is also responsible for setting the strategic direction of health information technology, including the development of online services to book appointments, the setting of quality standards for electronic medical record-keeping and prescribing, and the IT infrastructure of the NHS.

The National Institute for Health and Clinical Excellence (NICE) sets guidelines for clinically effective treatments and appraises new health technologies for their efficacy and cost-effectiveness. The CQC ensures basic standards of safety and quality through provider registration and monitors care standards achieved (described further below). It can require closure of services if serious quality concerns are identified.

The 2012 Act extended Monitor's role to being the economic regulator of public and private providers, with powers to intervene if performance deteriorates significantly. Monitor licenses all providers of NHS-funded care and may investigate potential breaches of NHS cooperation and competition rules and mergers involving NHS foundation trusts. Where such mergers are found to be prima facie undesirable, they are referred to the Office of Fair Trading and the Competition Commission.

Healthwatch England promotes patient interests nationally. In each community, local Healthwatches support people who make complaints about services; quality concerns may be reported to Healthwatch England, which can then recommend that the Care Quality Commission (CQC) take action. In addition, local NHS bodies, including general practices, hospital trusts, and CCGs, are expected to support their own patient engagement groups and initiatives. The Department of Health owns NHS Choices, the primary website for public information about health conditions, the location and quality of health services, and other information. The website, which also offers a platform for user feedback, received 27 million visits a month in 2012–13 (NHS Choices, 2013).



What are the major strategies to ensure quality of care?

The CQC has responsibility for the regulation of all health and adult social care in England. All providers, including institutions, individual partnerships, and solo practitioners, must be registered with the CQC, which monitors performance using nationally set quality standards and investigates individual providers when concerns have been raised (e.g., by patients). It rates hospitals' inspection results and can close down poorly performing services. New "fundamental standards" for all health and social care came into force in 2015 (Department of Health, 2014a). The monitoring process includes results of national patient experience surveys.

NICE develops quality standards covering the most common conditions occurring in primary, secondary, and social care. National strategies have been published for a range of conditions, from cancer to trauma. There are national registries for key disease groups and procedures. Maximum waiting times have been set for cancer treatment, elective treatments, and emergency treatment. A website, NHS Evidence, provides professionals and patients with up-to-date clinical guidelines. Support is also provided by NHS Quality Improvement, part of NHS England.

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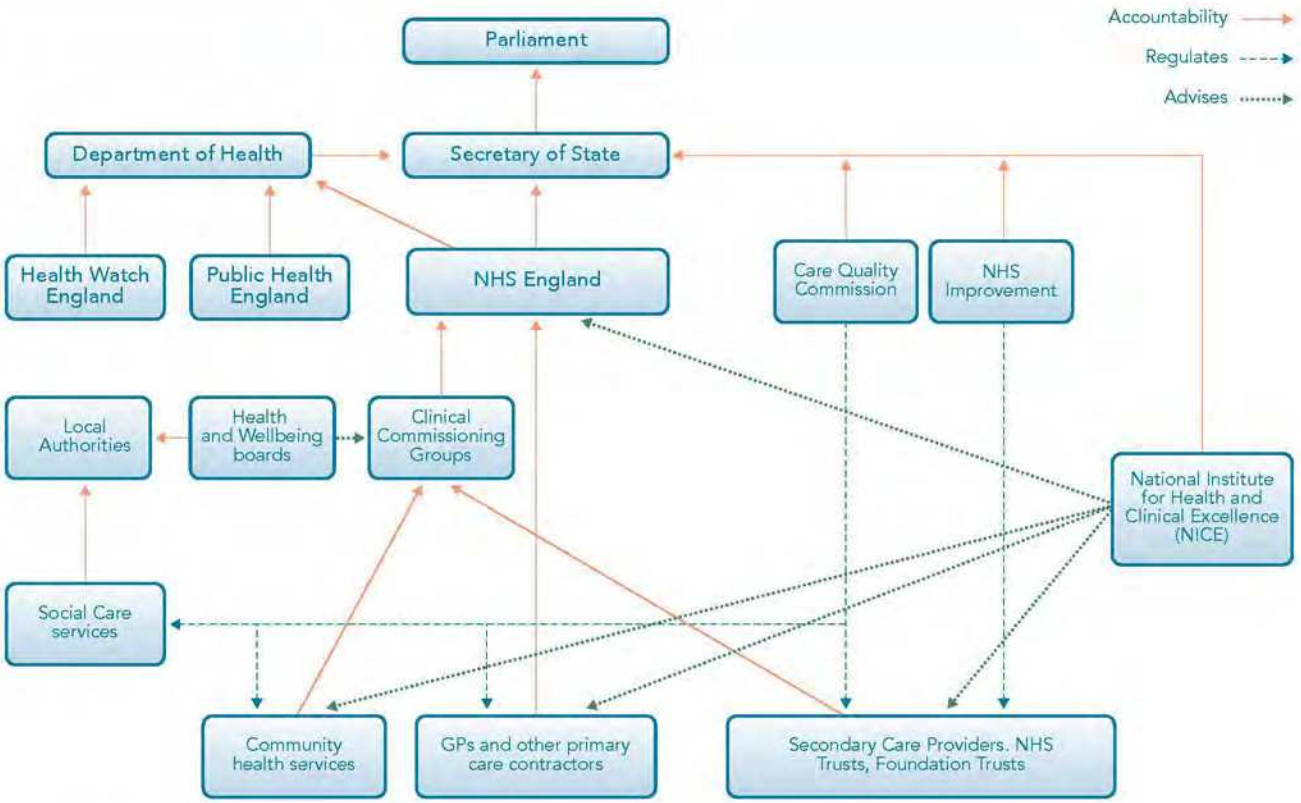
Organization of the Health System in England



Source: R. Thorlby and S. Arora, Nuffield Trust, 2014.

Information on the quality of services at the organization, department, and (for some procedures) physician levels is published on NHS Choices. Results of inspections by the CQC are also publicly accessible. The Quality and Outcomes Framework provides general practices with financial incentives to improve quality. General practices are awarded points (determining part of their remuneration) for keeping a disease registry of patients with certain diseases or conditions and their management and treatment. For hospitals, 2.5 percent of contract value is linked to the achievement of a limited number of quality goals through the Commissioning for Quality and Innovation initiative. In addition, DRG rates for some procedures are linked to best practice.

All doctors are required by law to have a license to practice from the General Medical Council. Similar requirements apply to all professions working in the health sector. A process of revalidation every five years is being introduced for doctors. Providers of hospital services also must be registered with the CQC.

What is being done to reduce disparities?

The Secretary of State, NHS England, and CCGs have a legal duty to "have regard" for the need to reduce health disparities, although the applicable legislation does not specify what action needs to be taken. NHS England publishes an annual report on the actions and progress being made in reducing disparities in access and outcomes, by gender, disability, age, socioeconomic status, and ethnicity (NHS England, 2015b). Strategies include ensuring that local areas receive adequate resources to tackle inequalities and that the outcomes for at-risk groups are routinely monitored.

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What is being done to promote delivery system integration and care coordination?

GPs increasingly work in multipartner practices that employ nurses and other clinical staff, who carry out much of the routine monitoring of patients with long-term conditions. These practices also have some of the features of a medical home—that is, they direct patients to specialists in hospitals or to community-based professionals, like dieticians and community nurses, and hold treatment records of their patients. GPs are responsible for care coordination as part of their overall contract; to improve coordination for older patients, the latest version of the contract (2014–15) requires practices to have a "named accountable GP" for all patients over age 75. GPs also have financial incentives to provide continuous monitoring of patients with the most common chronic conditions, such as diabetes and heart disease.

The 2012 Act charged NHS England, Monitor, and CCGs with promoting integrated care—closer links between hospital- and community-based health services, including primary and social care. The health and well-being boards within local authorities are intended to promote integration between NHS and local authority services, particularly at the intersection of hospital and social care.

The government announced in 2013 the selection of 14 "Pioneer" integration pilot programs, aimed at improving coordination of health and care services for patients most at risk of having to undergo unplanned or emergency treatment. The Better Care Fund provides GBP3.8 billion (USD5.4 billion), pooled from existing health and social care budgets, for integration projects by local health and social care commissioners starting in 2015–16. Health and well-being boards have submitted plans for these funds with a range of objectives, including a reduction in emergency hospital admissions by 3.5 percent (Local Government Association, 2013).

What is the status of electronic health records?

The NHS number assigned to every registered patient serves as a unique identifier. Most general practice patient records are computerized. Some practices use electronic systems to allow patients to make appointments or email their GP, but there is no requirement for practices to have that capability. Records are not routinely linked between providers.

A move to make primary, urgent, and emergency care services paperless by 2018, and all other parts of the NHS by 2020, is being enforced by requirements that NHS organizations show progress toward that end in the intervening years; they risk having funding removed if universal digital care records are not implemented by 2020.

NHS Choices will serve as a single point of access for patients to register with a GP, book appointments and order prescriptions, access apps and digital tools, speak to their doctor online or via video link, and view their full health record (Department of Health 2014c). All NHS patients have the right of access to their own health records (in some cases it is possible electronically) and can apply in writing to have a copy of their records held by their general practice, hospital, or dentist. By 2016, all patients will be able to have access to their GP electronic record in full, and by 2018 it is hoped that access will extend to data from all health and health care interactions.

Electronic transfers are widely used by GPs to send prescriptions to pharmacies, and for the storage and distribution of digital scans, X-rays, and other images.

NHS England has been developing a program for collecting data and for linking electronic records from general practice with those from hospitals and other care settings, for purposes of research and planning in health and social care services (NHS England, 2014b). Full implementation has been delayed because of concerns about confidentiality, but piloting in 265 general practices started in 2014.

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How are costs contained?

Rather than using patient cost-sharing or imposing direct constraints on supply, costs in the NHS are constrained by a global budget that cannot be exceeded. NHS budgets are set at the national level, usually on a three-year cycle. CCGs are allocated funds by NHS England, which closely monitors their financial performance to prevent overspending. They are expected to achieve a balanced budget each year.

The current economic situation has resulted in a largely flat NHS budget against a backdrop of rising demand. Between March 2010 and March 2015, the NHS budget rose by between 0.6 percent and 0.9 percent (in real terms), versus the 5.6 percent growth between 1996–97 and 2009–10 (King's Fund, 2015b). NHS England (2014a) estimated that the gap between rising demand and a continuation of this minimal increase in funding would be equivalent to GBP30 billion (USD42.4 billion) per year by 2020–21, assuming no additional efficiencies, but also that efficiencies equivalent to 2 percent to 3 percent of the annual budget are possible, versus a historic rate of 0.8 percent.

Although some of the savings targets have been met in the past five years, the financial pressure on the NHS is being associated with some deterioration in quality of care—notably waiting time targets (Nuffield Trust and Health Foundation, 2015).

Cost-containment strategies to date include freezing staff pay increases, supporting increased use of generic drugs, reducing DRG payments for hospital activity, managing demand, and reducing administration costs (King's Fund, 2015a). There are a number of tools for local purchasers to maximize value by addressing unwarranted variations in utilization and clinical practice, provided by the government-funded "Rightcare" program. Local purchasers can also run competitive tenders for certain services.

What major innovations and reforms have been introduced?

In October 2014, NHS bodies, led by NHS England, published the *Five Year Forward View*, which sets out the challenges facing the NHS and a series of strategies to address them (NHS England, 2014a). These included setting up a number of pilot programs across England to test new models of care known as "vanguards." To date there are 37 vanguard sites, which focus on scaled-up primary care, enhanced health care in long-term care homes, vertically integrated hospital and community care, and networks to improve emergency care. NHS England hopes that, among other benefits, evaluations of the program will lead to better tools for identifying those at risk of becoming high-need, high-cost patients, and to the development of capitated contracts to incentivize providers to collaborate in the care of complex patients. *The Five Year Forward View* also sets out strategies to improve health and well-being, including a diabetes prevention initiative (NHS England, 2015a).

The primary challenge facing the NHS is finding a way to redesign services and invest in prevention while at the same time generating efficiencies without compromising service quality or access. In November 2014, the National Audit Office reviewed the financial health of hospital providers in the NHS and warned that the trend of increasing financial distress was unsustainable (National Audit Office, 2014). The new Conservative government elected in May 2015 endorsed the *Five Year Forward View* and committed an additional GBP8 billion (USD11 billion) per year. But measured against the GBP30 billion (USD42 billion) gap identified by NHS England, this additional funding equates to an annual savings target of GBP22 billion (USD31 billion). Moreover, this funding will need to cover the implementation of new pledges, made in the election manifesto, to implement full seven-day working weeks in hospitals and general practice by 2020.

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The French Health Care System, 2015

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What is the role of government?

The provision of health care in France is a national responsibility. The Ministry of Social Affairs, Health, and Women's Rights is responsible for defining national strategy (Touraine, 2014). The French system has evolved from a labor-based Bismarckian system to a mixed public–private system. Over the past two decades, however, the state has been increasingly involved in controlling health expenditures funded by statutory health insurance (SHI).

Planning and regulation within health care involve negotiations among provider representatives, the state, and SHI. Outcomes of these negotiations are translated into laws passed by parliament.

In addition to setting national strategy, the responsibilities of the central government include allocating budgeted expenditures among different sectors (hospitals, ambulatory care, mental health, and services for disabled residents) and, with respect to hospitals, among regions.

The Administration of Health and Social Affairs is represented by Regional Health Agencies, which are responsible for population health and health care, including prevention and care delivery, public health, and social care. Health and social care for elderly and disabled people come under the jurisdiction of the General Council, which is the governing body at the local level.

Who is covered and how is insurance financed?

Publicly financed health insurance: Total health expenditures constituted 11 percent of GDP in 2013, of which 76 percent was publicly financed (DREES, 2015).

SHI is financed by employer and employee payroll taxes (64%); a national earmarked income tax (16%); taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (12%); state subsidies (2%); and transfers from other branches of Social Security (6%) (Assurance Maladie, 2015).

Coverage is universal and compulsory, provided to all residents by noncompetitive SHI. SHI eligibility is either gained through employment or granted, as a benefit, to students, to retired persons, and to unemployed adults who were formerly employed (and their families). Citizens can opt out of SHI only in rare cases (e.g., individuals working for foreign companies).

The state covers the insurance costs of residents who are not eligible for SHI, such as the long-term unemployed, and finances health services for undocumented immigrants who have applied for residence. Visitors from elsewhere in the European Union (EU) are covered by an EU insurance card. Non-EU visitors are covered for emergency care only.

Private health insurance: Most voluntary health insurance (VHI) is complementary, covering mainly the copayments for usual care, balance billing, and vision and dental care (minimally covered by SHI). Complementary insurance is provided mainly by not-for-profit, employment-based mutual associations or provident institutions, which are allowed to cover only copayments for care provided under SHI; 95 percent of the population is covered either through employers or via means-tested vouchers. Private for-profit companies offer both supplementary and complementary health insurance, but only for a limited list of services.

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VHI finances 13.8 percent of total health expenditure. The extent of VHI coverage varies widely, but all VHI contracts cover the difference between the SHI reimbursement rate and the service fee according to the official fee schedule. Coverage of balance billing is also commonly offered, and most contracts cover the balance for services billed at up to 300 percent of the official fee.

To reduce inequities in coverage stemming from variations in access and quality, standards for employer-sponsored VHI were established by law in 2013. By 2016, all employees will benefit from employer-sponsored insurance (for which they pay 50% of the cost), which would cover at least 125 percent of SHI fees for dental care and EUR100 (USD121) for vision care per year.[1] The population of beneficiaries without supplementary insurance is estimated at 4 million. Choice among insurance plans is determined by the industry in which the employer operates (DREES, 2015).



What is covered?

Services: Lists of covered procedures, drugs, and medical devices are defined at the national level and apply to all regions of the country. The Ministry of Health, a pricing committee within the ministry, and SHI funds all play roles in setting these lists, rates of coverage, and prices.

SHI covers the following: hospital care and treatment in public or private rehabilitation or physiotherapy institutions; outpatient care provided by general practitioners, specialists, dentists, and midwives; diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals; prescription drugs, medical appliances, and prostheses that have been approved for reimbursement; and prescribed health care–related transportation and home care. It also partially covers long-term hospice and mental health care, and provides only minimal coverage of outpatient vision and dental care.

While preventive services in general receive limited coverage, there is full reimbursement for targeted services and populations, e.g., immunization, mammography, and colorectal cancer screening.

Cost-sharing and out-of-pocket spending: Cost-sharing takes three forms: coinsurance; copayments (the portion of fees not covered by SHI); and balance billing in primary and specialist care. In 2013, total out-of-pocket spending made up 8.8 percent of total health expenditures (excluding the portion covered by supplementary insurance), a lower percentage than in previous years, possibly because of the agreement signed between physicians' unions and government to limit extra billing (DREES, 2015). In exchange for a voluntary restriction on extra billing to no more than twice the official fee, this contract offers patients partial reimbursement of extra billing by SHI and reduced social charges for physicians.

Most out-of-pocket spending is for dental and vision services, for which official fees are very low, not more than a few euros for glasses or hearing aids and a maximum of EUR200 (USD241) for dentures, but all of these are commonly balance-billed at amounts over 10 times the official fee. The share of out-of-pocket spending on dental and optical services is decreasing, however, while that on drugs is increasing, owing to increased VHI coverage of dental and optical care and increasing numbers of delisted drugs, as well as a rise in self-medication (DREES, 2015).

Coinsurance rates are applied to all health services and drugs listed in the benefit package, and vary by:

- type of care (inpatient, 20%; doctor visits, 30%; and dental, 30%)
- effectiveness of prescription drugs (highly effective drugs, like insulin, carry no coinsurance; rates for all other drugs are 40%–100%, based on therapeutic value)
- compliance with the recently implemented gatekeeping system

[1] Please note that, throughout this profile, all figures in USD were converted from EUR at a rate of about EUR0.83 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for France.

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The table below lists nonreimbursable copayments for various services. These apply up to an annual ceiling of EUR50 (USD60). There are no deductibles.

Service	Copayment	
	Euros	U.S. Dollars
Inpatient hospital day	18	22
Doctor visit	1.00	1.20
Prescription drug	0.50	0.60
Ambulance	2.00	2.40
Hospital	18	22

Safety net: People with low incomes are entitled to free or state-sponsored VHI, free vision care, and free dental care, with the total number of such beneficiaries estimated at around 10 percent of the population (DREES, 2015). Exemptions from coinsurance apply to individuals with any of 32 specified chronic illnesses (13% of the population, with exemption limited to the treatments for those conditions); individuals who benefit from either complete state-sponsored medical coverage (3% of the population) or means-tested vouchers for complementary health insurance (6% of the population); and individuals receiving invalidity and work-injury benefits (Fonds CMU, 2014). Hospital coinsurance applies only to the first 31 days in hospital, and some surgical interventions are exempt. Children and people with low incomes are exempt from paying nonreimbursable copayments.

How is the delivery system organized and financed?

Collective agreements between representatives of the health professions and SHI, signed at the national level, apply to all but those professionals who expressly opt out.

Primary care: There are roughly 102,000 primary care physicians (GPs) and 118,000 specialists in France. About 46 percent of physicians are self-employed, more GPs (59%) than specialists (36%) (INSEE 2015; CISS 2014). Forty-two percent of GPs, mostly younger doctors, are in group practices. An average practice is made up of two to three physicians. Seventy-five percent of practices are made up exclusively of physicians; the remaining practices comprise a range of allied health professionals, typically paid fee-for-service.

There is a voluntary gatekeeping system for adults age 16 and older, with financial incentives offered for registering with a GP or specialist (Cour des Comptes, 2013).

Self-employed GPs are paid mostly fee-for-service and can receive a yearly capitated per-person payment of EUR40 (USD48) to coordinate care for patients with a chronic condition (Assurance Maladie, 2015). In addition, up to EUR5,000 (USD6,031) annually is provided for achieving targets related to the use of computerized medical charts, electronic claims transmission, delivery of preventive services such as immunization, compliance with guidelines for diabetic and hypertensive patients, generic prescribing, and limited use of psychoactive drugs for elderly patients.

Since 2013, GPs also can enter into a contractual agreement under which they are guaranteed a monthly income of EUR6,900 (USD8,322) if they set up their practice in a region with insufficient physician supply (Ministry of Health, 2014). Moreover, they can work part-time in multidisciplinary medical centers and receive a salary or capitated payment. For those who elect to work full-time in medical centers, the guaranteed salary is around EUR50,000 (USD60,300) (Quotidien du Médecin, 2015).

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The average income of primary care doctors in 2011 was EUR82,020 (USD98,925), 94 percent of which came from fees (INSEE 2015) and the remainder from financial incentives and salary. Fees, set by the Ministry of Health and SHI, have been frozen since 2011 (Cour des Comptes 2013).

Experimental GP networks providing chronic care coordination, psychological services, dietician services, and other care not covered by SHI are financed by earmarked funds from the Regional Health Agencies (Nolte, 2008).

Outpatient specialist care: About 36 percent of outpatient specialist care providers are exclusively self-employed and paid on a fee-for-service basis; the rest are either fully salaried by hospitals or have a mix of income. In October 2014, participation in pay-for-performance programs was extended to all self-employed physicians, including specialists, who must meet disease-specific quality targets in addition to those targets that apply to GPs. The average income derived from pay-for-performance is EUR5,480 (USD6,609) per physician (Cour des Comptes 2014); such income constitutes less than 2 percent of total funding for outpatient services.

Patients can choose among specialists upon referral by a GP, with the exception of gynecology, ophthalmology, psychiatry, and stomatology (Assurance Maladie, 2015). Bypassing referral results in reduced SHI coverage.

The specialist fee, set by SHI, is EUR28 (USD34), but specialists can balance-bill. Half of specialists are in group practices, which are increasing among specialties that require major investments, such as nuclear medicine, radiotherapy, pathology, and digestive surgery (Sénat, 2014).

Specialists working in public hospitals may see private-pay patients, on an outpatient or an inpatient basis, but they must pay a percentage of their fees to the hospital. A 2013 report to the Ministry of Health estimated that 10 percent of the 46,000 hospital specialists in surgery, radiology, cardiology, and obstetrics had treated private patients. The mounting discontent over excessive balance billing revealed in the press, together with the claim of unfair competition made by private clinics, has prompted several public inquiries—the latest of which resulted in recommendations to increase public control over this activity (Ministère de la Santé 2013).

Administrative mechanisms for paying primary care doctors and specialists: Patients pay the full fee (reimbursable portion and balance billing, if any) and claim reimbursement covering the full sum or less, depending on coverage, minus EUR1.00 (USD1.20), capped at a maximum of EUR50 (USD60) per patient per year. The 2015 Health Law included a contentious item stipulating that by 2017 patients will pay directly only for balance billing, and the reimbursable fee will be paid directly by SHI.

After-hours care: After-hours care is delivered by the emergency departments of public hospitals, private hospitals that have signed an agreement with their Regional Health Agency, self-employed physicians who work for emergency services, and, more recently, public facilities financed by SHI and staffed by health professionals on a voluntary basis. Primary care physicians are not mandated to provide after-hours care.

Physicians are paid an hourly rate, regardless of the number of patients seen. Emergency services can be accessed via the national emergency phone number, which is staffed by trained professionals who determine the type of response needed. Feasibility of telephone or telemedicine advice is currently under assessment; it would include sharing information from the patient's electronic medical record with the patient's primary care doctor. Publicly funded multidisciplinary health centers with self-employed health professionals (physicians and nonphysicians) allow better after-hours access to care in addition to more comprehensive care; fee-for-service payment is the rule for these centers (IRDES, 2014).

Hospitals: Public institutions account for about two-thirds of hospital capacity and activity, private for-profit facilities account for another 25 percent, and private nonprofit facilities, the main providers of cancer treatment, make up the remainder (DREES, 2015). Since 2008, all hospitals and clinics are reimbursed via the diagnosis-related group (DRG) system, which applies to all inpatient and outpatient admissions and covers physicians' salaries. Bundled payment by episode of care does not exist.

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Public hospitals are funded mainly by statutory health insurance (80%), with voluntary insurance and direct patient payment accounting for their remaining income. Public and private nonprofit hospitals also benefit from grants that compensate research and teaching (up to an additional 13% of the budget) as well as the provision of emergency services and organ harvesting and transplantation (on average, an additional 10%–11% of a hospital's budget). Private, for-profit clinics owned either by individuals or, increasingly, by large corporations have the same funding mechanism as public hospitals, but the share of respective payers differs. Doctors' fees are billed in addition to the DRG in private clinics, and DRG payment rates are lower there than they are in public or nonprofit hospitals. This disparity is justified by differences in the size of facilities, the DRG mix, and the patients' characteristics (age, comorbid conditions, and socioeconomic status) (IRDES, 2013). Rehabilitative hospitals also have a prospective payment system based on length of stay and care intensity.

Mental health care: Services for mentally ill people are provided by the public and private health care sectors, with an emphasis on community-based provision. Public care is provided within geographically determined areas and includes a wide range of preventive, diagnostic, and therapeutic inpatient and outpatient services. Ambulatory centers provide primary ambulatory mental health care, including home visits.

Mental health care is not formally integrated with primary care, but a large number of disorders are also treated on an outpatient basis by GPs or private psychiatrists or psychologists, some of them practicing psychotherapy and, occasionally, psychoanalysis.

Statutory health insurance covers care provided by GPs and psychiatrists in private practice, public mental health care dispensaries, and private psychiatric hospitals. Copayments do not apply to persons with a diagnosed long-term mental illness. Care provided by psychotherapists or psychoanalysts is fully financed by patients or covered by VHI. Copayments and the flat-rate fee for accommodation can also be fully covered by VHI.

Long-term care and social supports: Total expenditure for long-term care in 2013 was estimated to be EUR39 billion (USD47 billion), or 17 percent of total health expenditures (DREES, 2014). Statutory health insurance covers the medical costs of long-term care, while families are reponsible for the housing costs in hospices and other long-term facilities—on average, EUR1,500 (USD1,809) per month (Ministère de la Santé 2013(2)). End-of-life care in hospitals is fully covered. Some funding of care for the elderly and disabled comes from the National Solidarity Fund for Autonomy, which is in turn financed by SHI and the revenues from an unpaid working "solidarity" day. Local authorities, the general councils, and households also participate in financing these categories of care.

Home care for the elderly is provided mainly by self-employed physicians and nurses and, to a lesser extent, by community nursing services. Long-term care in institutions is provided in retirement homes and long-term care units, totaling roughly 10,000 institutions and 720,000 beds. Of these, 54 percent are public, 28 percent private nonprofit, and 18 percent for-profit, although the percentage of for-profit institutions is increasing (DREES, 2014).

In addition, temporary care for dependent patients and respite services for their caregivers are available without restrictions from the states or regions.

Means-tested monetary allowances are provided for the frail elderly. The allowance is adjusted in relation to the individual's dependence level, living conditions, and needs, as assessed by a joint health and social care team, and may be used for any chosen service and provider. About 1.1 percent of the total population is estimated to be eligible. Informal caregivers also benefit from tax deductions.

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What are the key entities for health system governance?

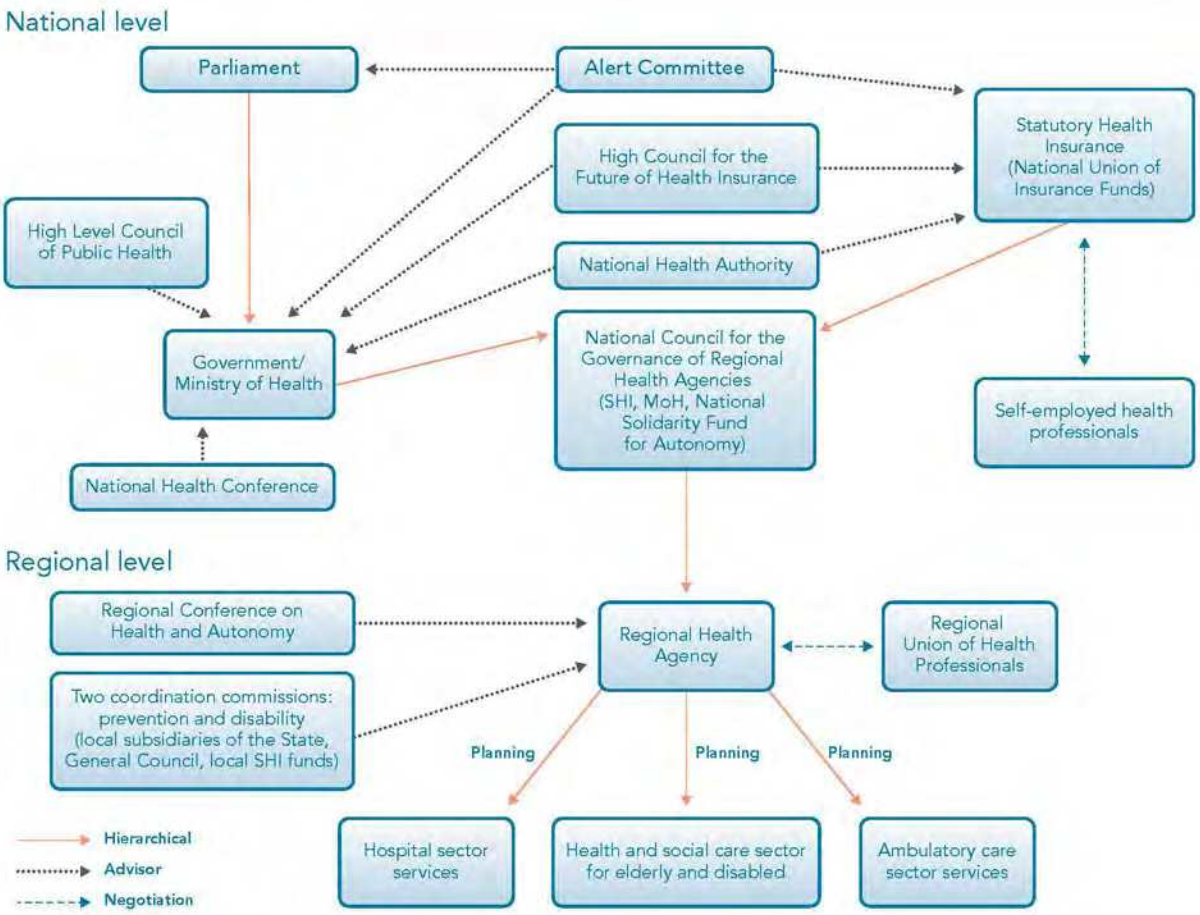
The Ministry of Health sets and implements government policy in the areas of public health and the organization and financing of the health care system, within the framework of the Public Health Act. It regulates roughly 75 percent of health care expenditure on the basis of the overall framework established by parliament, which includes a shared responsibility with statutory health insurers for defining the benefit package, setting prices and provider fees (including diagnosis-related group fees and copayments), and pricing drugs. The parliamentary "Alert" Committee provides a midyear assessment of health care expenditures and proposes corrective measures in case expenditures exceed the target by more than 0.75 percent.

The French Health Products Safety Agency oversees the safety of health products, from manufacturing to marketing. The agency also coordinates vigilance activities relating to all relevant products.

The Agency for Information on Hospital Care manages the information systematically collected from all hospital admissions and used for hospital planning and financing.

The remit of the National Agency for the Quality Assessment of Health and Social Care Organizations encompasses the promotion of patient rights and the development of preventive measures to avoid mistreatment, in particular in vulnerable populations such as the elderly and disabled, children, adolescents, and

Organization of the Health System in France



Notes: SHI: Statutory health insurance. MoH: Ministry of Health.

Source: Adapted from K. Chevreul, I. Durand-Zaleski, S. B. Bahrami et al., "France: Health System Review," *Health Systems in Transition*, vol. 12, no. 6, 2010, pp. xxi–xxii.

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socially marginalized people. It produces practice guidelines for the health and social care sector and evaluates organizations and services.

The National Health Authority (HAS) is the main health technology assessment body, with in-house expertise as well as the authority to commission assessments from external groups. The HAS remit is diverse, ranging from the assessment of drugs, medical devices, and procedures to publication of guidelines, accreditation of health care organizations, and certification of doctors.

Competition is limited to VHI, whose providers are supervised by the Mutual Insurance Funds Control Authority.

What are the major strategies to ensure quality of care?

National plans are developed for a number of chronic conditions (e.g., cancer, Alzheimer's), rare diseases, prevention, and healthy aging, in addition to the 104 targets set by the 2004 Public Health Act. These plans establish governance (e.g., the cancer plan to coordinate research and treatment in cancer and establish guidelines for medical practice and activity thresholds), develop tools, and coordinate existing organizations. All plans emphasize the importance of supporting caregivers and ensuring patients' quality of life, in addition to enforcing compliance with guidelines and promoting evidence-based practice.

The National Health Authority publishes an evidence-based basic benefit package for 32 chronic conditions. Further guidance on recommended care pathways covers chronic obstructive pulmonary disease, heart failure, Parkinson's, and end-stage renal disease (Assurance Maladie, 2015).

SHI and the Ministry of Health fund "provider networks" in which participating professionals share guidelines and protocols, agree on best practice, and have access to a common patient record. Regional authorities fund telemedicine pilot programs to improve care coordination and access to care for specific conditions (e.g., stroke) or populations (e.g., newborns, the elderly, prisoners). The PAERPA (Personnes Agées en Risque de Perte d'Autonomie) program, established in 2014 in nine pilot regions, is a nationwide endeavor to improve the quality of life and coordination of interventions for the frail elderly.

For self-employed physicians, certification and revalidation are organized by an independent body approved by the National Health Authority. For hospital physicians, both can be performed as part of the hospital accreditation process.

To ensure the lifelong quality of their practice, doctors, midwives, nurses, and other professionals must undergo continuous learning activities, which are audited every fourth or fifth year. Optional accreditation exists for a number of high-risk medical specialties (e.g., obstetrics and gynecology, surgery, cardiology). Accredited physicians can claim a deduction on their professional insurance premiums.

Hospitals must be accredited every four years; criteria and accreditation reports are publicly available on the National Health Authority website (www.has-sante.fr). CompaqH, a national program of performance indicators, also reports results on selected indicators. Quality assurance and risk management in hospitals are monitored nationally by the Ministry of Health, which publishes online technical information, data on hospital activity, and data on control of hospital-acquired infections. Currently, financial rewards or penalties are not linked to public reporting, although they remain a contested issue. Information on individual physicians is not available.

What is being done to reduce disparities?

There is a 6.3-year gap in life expectancy between males in the highest and males in the lowest social categories (DREES, 2015) and poorer self-reported health among those with state-sponsored or without any complementary insurance. The reduction of health inequities is a major target of the 2014 National Health Strategy, and the 2004 Public Health Act set targets for reducing inequities in access to care related to geographic availability of services (so far, only nurses have agreed to limit new practices in overserved areas), financial barriers (out-of-pocket payments will be limited by state-sponsored complementary insurance), and

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inequities in prevention related to obesity, screening, and immunization. A contractual agreement allows for the use of incentives for physicians practicing in underserved areas, the extension of third-party payment, and enforced limitations on denial of care.

National surveys showing regional variations in health and access to health are reported by the Ministry of Health (DREES, 2015).

What is being done to promote delivery system integration and care coordination?

Various quality-related initiatives aim to improve coordination of hospital, out-of-hospital, and social care (see above). At the regional level, telemedicine pilot programs are under way to coordinate health and social care services for target populations identified by the Regional Health Agencies, such as infants, prisoners, and persons with disabilities. Funding streams are pooled and earmarked for these pilots, and assessment is planned for 2016.

What is the status of electronic health records?

A high-level electronic health record (EHR) project is currently being implemented across the entire country. Approximately 551,000 patients, or 0.8 percent of the population, have an EHR, and an estimated 600 hospitals and 6,000 health professionals use them. Hospital-based and office-based professionals and patients have a unique electronic identifier, and any health professional can access the record and enter information subject to patient authorization. Interoperability is ensured via a chip on patients' health cards. By law, patients have full access to the information in their own records, either directly or through their GP. All "structured information" included in EHRs must be communicated, but handwritten notes are excluded. The sharing of information between health and social care professionals is not currently permitted, but will be tested as part of the PAERPA program for hospice residents.

A national agency for health information systems was created for the purpose of expanding uptake and interoperability of existing systems (ASIP, 2014), and the health records are available on a government website.

How are costs contained?

SHI has faced large deficits over the past 20 years, but it fell from an annual EUR10B–12B (USD12.1B–14.5B) in 2003 to EUR6.2B (USD7.5B) in 2014. This trend is the result of a range of initiatives, including a reduction in the number of acute-care hospital beds; the removal of 600 drugs from public reimbursement; an increase in generic prescribing and the use of over-the-counter drugs; a reduction in the price of generic drugs; and a reduction of the official fees for self-employed radiologists and biology labs. Other cost-containment measures include central purchasing to better negotiate costs, increasing the share of outpatient surgery, and reducing duplicate testing. Competition is not used as a cost-control mechanism. Global budgets are used only in price–volume agreements for drugs or devices. As described above, patient cost-sharing mechanisms include increased copayments for patients who refuse generics or do not use the gatekeeping system (Assemblée Nationale, 2013).

A number of initiatives to reduce "low-value" care, launched by SHI and HAS, include pay-for-performance to reduce prescription of benzodiazepines for elderly persons; reductions in avoidable hospital admissions for patients with heart failure; early discharge after orthopedic surgery and normal childbirth; information on the absence of the benefit of prostate cancer screening; using DRG payments to incentivize shifts to outpatient surgery; establishing guidelines for the number of off-work days according to disease or procedure; strengthening controls for the prescription of expensive statins and new anticoagulants; encouraging the use of Avastin over Lucentis, and other less costly biosimilar drugs; and testing the use of taxi vouchers, instead of ambulances, for chronically ill patients (Assurance Maladie, 2015).

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What major innovations and reforms have been introduced?

The new Health Law, based on the 2012 pledge by the newly elected government to reduce health inequities and on the 2014 health strategy (Touraine, 2014), was passed in April 2015 to replace the previous law, dating back to 2004. It has 57 articles, the most prominent being the deployment of direct SHI payments to self-employed GPs and a strong commitment to public health and prevention. The direct GP payments have been strongly opposed by physicians' unions on the grounds that such payments might be delayed by software dysfunction (versus immediate payment at the end of the consultation) and that physicians would become SHI "employees," and could be pressured into giving cheap care instead of appropriate care. The timetable is to have a full deployment by 2017 (the year of the presidential election).

Prevention and public health measures aim to reduce addictions, eating disorders, and obesity, and include measures to fight binge drinking and anorexia. They support the mandatory neutral cigarette pack, the ban on soda fountains, experimentation with medically supervised IV drug injecting facilities, and mandatory nutrition information on packaged foods (Parlement, 2015).

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The German Health Care System, 2015

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What is the role of government?

Health insurance is mandatory for all citizens and permanent residents of Germany. It is provided by competing, not-for-profit, nongovernmental health insurance funds ("sickness funds"; there were 124 as of January 2015) in the statutory health insurance (SHI) system, or by substitutive private health insurance (PHI). States own most university hospitals, while municipalities play a role in public health activities, and own about half of hospital beds. However, the various levels of government have virtually no role in the direct financing or delivery of health care. A large degree of regulation is delegated to self-governing associations of the sickness funds and the provider associations, which together constitute the most important body, the Federal Joint Committee.

Who is covered and how is insurance financed?

Publicly financed health insurance: In 2013, total health expenditure was 11.5 percent of GDP, of which 73 percent was public and 58 percent was SHI spending (Federal Statistical Office, 2015). General tax–financed federal spending on "insurance-extraneous" benefits provided by SHI (e.g., coverage for children) amounted to about 4.4 percent of total expenditure in 2014 and 2015. Sickness funds are funded by compulsory contributions levied as a percentage of gross wages up to a ceiling. Coverage is universal for all legal residents. All employed citizens (and other groups such as pensioners) earning less than EUR54,900 (USD69,760) per year as of 2015 are mandatorily covered by SHI, and their nonearning dependents are covered free of charge.[1] Individuals whose gross wages exceed the threshold and the previously SHI-insured self-employed can remain in the publicly financed scheme on a voluntary basis (and 75% do) or purchase substitutive PHI, which also covers civil servants. About 86 percent of the population receive their primary coverage through SHI and 11 percent through substitutive PHI. The remainder (e.g., soldiers and policemen) are covered under special programs. Visitors are not covered through German SHI. Undocumented immigrants are covered by social security in case of acute illness and pain, as well as pregnancy and childbirth.

As of 2015, the legally set uniform contribution rate is 14.6 percent of gross wages. Both the legal contribution rate for employees (0.9%) and the supplementary premiums set by sickness funds have been abolished and replaced by a supplementary income-dependent contribution rate determined by each sickness fund individually (Busse and Blümel, 2014). As of 2015, the supplementary contribution rate is, on average, 0.9 percent—that is, most of the SHI-insured pay the same as previously, but rates range between 0 percent and 1.3 percent (Federal Association of Sickness Funds, 2015).

This contribution also covers dependents (nonearning spouses and children). Earnings above EUR49,500 (USD63,360) per year (as of 2015) are exempt from contribution. Sickness funds' contributions are centrally pooled and then reallocated to individual sickness funds using a risk-adjusted capitation formula, taking into account age, sex, and morbidity from 80 chronic and/or serious illnesses.

Private health insurance: In 2014, 8.8 million people were covered through substitutive private health insurance (Association of Private Health Insurance Companies, 2015). PHI is especially attractive for young people with a good income, as insurers may offer them contracts with more extensive ranges of services and lower premiums.

[1] Please note that, throughout this profile, all figures in USD were converted from EUR at a rate of about EUR0.79 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Germany.

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There were 42 substitutive PHI companies in June 2015 (of which 24 were for-profit) covering the two groups exempt from SHI (civil servants, whose health care costs are partly refunded by their employer, and the self-employed) and those who have chosen to opt out of SHI. All of the PHI-insured pay a risk-related premium, with separate premiums for dependents; risk is assessed only upon entry, and contracts are based on lifetime underwriting. Government regulates PHI to ensure that the insured do not face large premium increases as they age and are not overburdened by premiums if their income decreases.

PHI also plays a mixed complementary and supplementary role, covering minor benefits not covered by SHI, access to better amenities, and some copayments (e.g., for dental care). The federal government determines provider fees in substitutive, complementary, and supplementary PHI through a specific fee schedule. There are no government subsidies for complementary and supplementary PHI. In 2013, all forms of PHI accounted for 9.2 percent of total health expenditure (Federal Statistical Office, 2015).



What is covered?

Services: SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, optometry, physical therapy, prescription drugs, medical aids, rehabilitation, hospice and palliative care, and sick leave compensation. Home care is covered by long-term care insurance (LTCI). SHI preventive services include regular dental checkups, child checkups, basic immunizations, checkups for chronic diseases, and cancer screening at certain ages. All prescription drugs are covered unless explicitly excluded by law (mainly so-called lifestyle drugs) or disallowed following evaluation. While the broader framework of the benefits package is legally defined, specifics are decided upon by the Federal Joint Committee (see below). Long-term care services are covered separately by the LTCI scheme (see below).

Cost-sharing and out-of-pocket spending: Out-of-pocket (OOP) spending accounted for 13.6 percent of total health spending in 2013, mostly on nursing homes, pharmaceuticals, and medical aids (Federal Statistical Office, 2015).

Copayments include EUR5.00 (USD6.40) to EUR10.00 (USD12.70) per outpatient prescription, EUR10.00 per inpatient day for hospital and rehabilitation stays (for the first 28 days per year), and EUR5.00 to EUR10.00 for prescribed medical devices. Sickness funds offer selectable tariffs with a range of deductibles and no-claims bonuses. Preventive services do not count toward the deductible. SHI-contracted physicians are not allowed to charge above the fee schedule for services in the SHI benefit catalogue. However, a list of "individual health services" outside the comprehensive range of SHI coverage may be offered to patients paying OOP.

Safety nets: Children under 18 years of age are exempt from cost-sharing. For adults, there is an annual cap on cost-sharing equal to 2 percent of household income; part of a household's income is excluded from this calculation for additional family members. About 0.4 million SHI insureds exceeded the 2 percent cap in 2013 and were exempted from further cost-sharing. The cap is lowered to 1 percent of annual gross income for qualifying chronically ill people; to qualify, those people have to demonstrate that they attended recommended counseling or screening procedures prior to becoming ill. Nearly 6.5 million people, or around 9 percent of all the SHI-insured, benefited from this regulation in 2013 (Federal Statistical Office, 2015). Unemployed people contribute to SHI in proportion to their unemployment entitlements. For the long-term unemployed, government contributes on their behalf.



How is the delivery system organized and financed?

Physicians: General practitioners (GPs) and specialists in ambulatory care who get reimbursed by SHI are by law mandatory members of regional associations that negotiate contracts with sickness funds. Regional associations of SHI-accredited physicians are responsible for coordinating care requirements within their region, and act as financial intermediaries to the sickness funds and the physicians in ambulatory care. However, ambulatory physicians typically work in their own private practices—around 60 percent in solo practice and 25 percent in dual practices. Most physicians employ doctors' assistants, while other nonphysicians (e.g., physiotherapists)

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have their own premises. In 2014, of the roughly 109,600 self-employed SHI-accredited physicians in ambulatory care, 52,800 (48%) were practicing as family physicians (including GPs, internists, and pediatricians) and 56,800 (52%) as specialists. There were about 2,000 multispecialty clinics with more than 13,000 physicians (10% of ambulatory care physicians) in 2014. Around 11,000 physicians working in multispecialty clinics are salaried employees, while 12,000 are employed in practices of self-employed physicians. The total number of ambulatory care physicians is more than 130,000 (Federal Association of SHI Physicians, 2015). Some specialized outpatient care is provided by hospital specialists, including treatment of rare diseases and of severe progressive forms of disease, as well as highly specialized procedures.

Individuals have free choice among GPs, specialists, and, if referred to inpatient care, hospitals. Registration with a family physician is not required, and GPs have no formal gatekeeping function. However, sickness funds are required to offer their members the option to enroll in a "family physician care model," which has been shown to provide better services and also often provides incentives for complying with gatekeeping rules.

SHI-accredited physicians in ambulatory care (GPs and specialists) are generally reimbursed on a fee-for-service (FFS) basis according to a uniform fee schedule negotiated between sickness funds and physicians (see below). Payments are limited to predefined maximum numbers of patients per practice and reimbursement points per patient, setting thresholds on the number of patients and treatments per patient for which a physician can be reimbursed. For the treatment of private patients, GPs and specialists also get an FFS, but the private tariffs are usually higher than the tariffs in the SHI uniform fee schedule. Pay-for-performance has not been established yet. The average reimbursement of a family physician is above EUR200,000 (USD254,000) per year, covering costs for personnel, etc., but excluding income from private patients, which varies substantially (Federal Association of SHI Physicians, 2015).

Financial incentives for care coordination can be part of integrated care contracts, but are not routinely implemented. The only regular financial incentive that GPs receive is a fixed annual bonus (EUR120, or USD152, in 2015) for patients enrolled in a Disease Management Program (DMP), in which physicians provide patient training and document patient data. Bundled payments are not common in primary care, but a regional initiative, "Healthy Kinzigtal" (Kinzigtal is a valley in southeast Germany), provides an example of a shared savings model offering primary care doctors and other providers financial incentives for integrating care across providers and services.

Administrative mechanisms for direct patient payments to providers: SHI physicians in ambulatory care bill their regional associations according to a uniform fee schedule; the associations are in turn reimbursed by sickness funds. Copayments or payments for services not included in the benefit catalogue are paid directly to the provider. In cases of private health insurance, patients pay up front and submit claims to the insurance company for reimbursement.

After-hours care: After-hours care is organized by the regional associations of SHI-accredited physicians to ensure access to ambulatory care around the clock. Physicians are obliged to provide after-hours care in their practice, with differing regional regulations. In some areas (e.g., Berlin), after-hours care has been delegated to hospitals. The patient is given a report of the visit afterwards to hand to his or her GP. There is also a tight network of emergency care providers (the responsibility of the municipalities). After-hours care assistance is also available via a nationwide telephone hotline (*116 117-Ärztlicher Bereitschaftsdienst*). Payment for ambulatory after-hours care is based on the above-mentioned fee schedules, again with differences in the amount of reimbursement for SHI and PHI.

Hospitals: Public hospitals make up about half of all beds, while private not-for-profits account for about a third. The number of private, for-profit hospitals has been growing in recent years (now around one-sixth of all beds). All hospitals are staffed principally by salaried doctors. Doctors in hospitals are typically not allowed to treat outpatients (similar to hospitalists in the U.S.), but exceptions are made if necessary care cannot be provided by office-based specialists. Senior doctors can treat privately insured patients on an FFS basis. Hospitals can also provide certain highly specialized services on an outpatient basis.

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The 16 state governments determine hospital capacity, while ambulatory care capacity is subject to rules set by the Federal Joint Committee. Inpatient care is paid per admission through a system of diagnosis-related groups (DRGs) revised annually, currently based on around 1,200 DRG categories. DRGs also cover all physician costs. Other payment systems like pay-for-performance or bundled payments have yet to be implemented in hospitals.

Mental health care: Acute psychiatric inpatient care is largely provided by psychiatric wards in general (acute) hospitals, while the number of hospitals providing care only for patients with psychiatric and/or neurological illness is low. In 2014, there were a total of 32,872 office-based psychiatrists, neurologists, and psychotherapists working in the ambulatory care sector (paid FFS) (Federal Association of SHI Physicians, 2015). Qualified GPs can provide basic psychosomatic services. Ambulatory psychiatrists are also coordinators of a set of SHI-financed benefits called "sociotherapeutic care" (which requires referral by a GP), to encourage the chronically mentally ill to use necessary care and to avoid unnecessary hospitalizations. To further promote outpatient care for psychiatric patients (particularly in rural areas with a low density of psychiatrists in ambulatory care), hospitals can be authorized to offer treatment in outpatient psychiatric departments.

Long-term care and social supports: LTCI is mandatory and usually provided by the same insurer as health insurance, and therefore comprises a similar public–private insurance mix. The contribution rate of 2.35 percent of gross salary is shared between employers and employees; people without children pay an additional 0.25 percent. The contribution rate will increase further by 0.2 percentage points in early 2017. Everybody with a physical or mental illness or disability (who has contributed for at least two years) can apply for benefits, which are: 1) dependent on an evaluation of individual care needs by the SHI Medical Review Board (leading either to a denial or to a grouping into currently one of three levels of care); and 2) limited to certain maximum amounts, depending on the level of care. Beneficiaries can choose between in-kind benefits and cash payments (around a quarter of LTCI expenditure goes to these cash payments). Both home care and institutional care are provided almost exclusively by private not-for-profit and for-profit providers. As benefits usually cover approximately 50 percent of institutional care costs only, people are advised to buy supplementary private LTCI. Since 2013, family caregivers get financial support through continuing payment of up to 50 percent of care payments if they provide care.

Hospice care is partly covered by LTCI if the SHI Medical Review Board has evaluated a care level. Medical services or palliative care in a hospice are covered by SHI. The number of inpatient facilities in hospice care has grown significantly over the past 15 years, to 200 hospices and 250 palliative care wards nationwide in 2014 (German Hospice and Palliative Association, 2015). Legislation has recently been discussed to improve hospice and palliative care with the aim of guaranteeing care in underserved rural areas and linking long-term care facilities more strongly to ambulatory palliative and hospice care.

What are the key entities for health system governance?

The German health care system is notable for two essential characteristics: 1) the sharing of decision-making powers between states, federal government, and self-regulated organizations of payers and providers; and 2) the separation of SHI (including the social LTCI) and PHI (including the private LTCI). SHI and PHI (as well as the two long-term care insurance systems) use the same providers—that is, hospitals and physicians treat both statutorily and privately insured patients, unlike many other countries.

Within the legal framework set by the Ministry of Health, the Federal Joint Committee has wide-ranging regulatory power to determine the services to be covered by sickness funds and to set quality measures for providers (see below). To the extent possible, coverage decisions are based on evidence from health technology assessments and comparative-effectiveness reviews. The Federal Joint Committee is supported by the Institute for Quality and Efficiency (IQWiG), a foundation legally charged with evaluating the cost-effectiveness of drugs with added therapeutic benefits, and the newly formed Institute for Quality and Transparency (IQTiG). The Federal Joint Committee has had 13 voting members: five from the Federal Association of Sickness Funds, two each from the Federal Association of SHI Physicians and the German

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Hospital Federation, one from the Federal Association of SHI Dentists, and three who are unaffiliated. Five patient representatives have an advisory role but no vote in the committee. Representatives of patient organizations have the right to participate in different decision-making bodies, e.g., the subcommittees of the Federal Joint Committee.

The Federal Association of Sickness Funds works with the Federal Association of SHI Physicians and the German Hospital Federation to develop the SHI ambulatory care fee schedule and the DRG catalogue, which are then adopted by bilateral joint committees.

What are the major strategies to ensure quality of care?

Quality of care is addressed through a range of measures broadly defined by law, and in more detail by the Federal Joint Committee. Structural quality is assured by the requirement that providers have a quality

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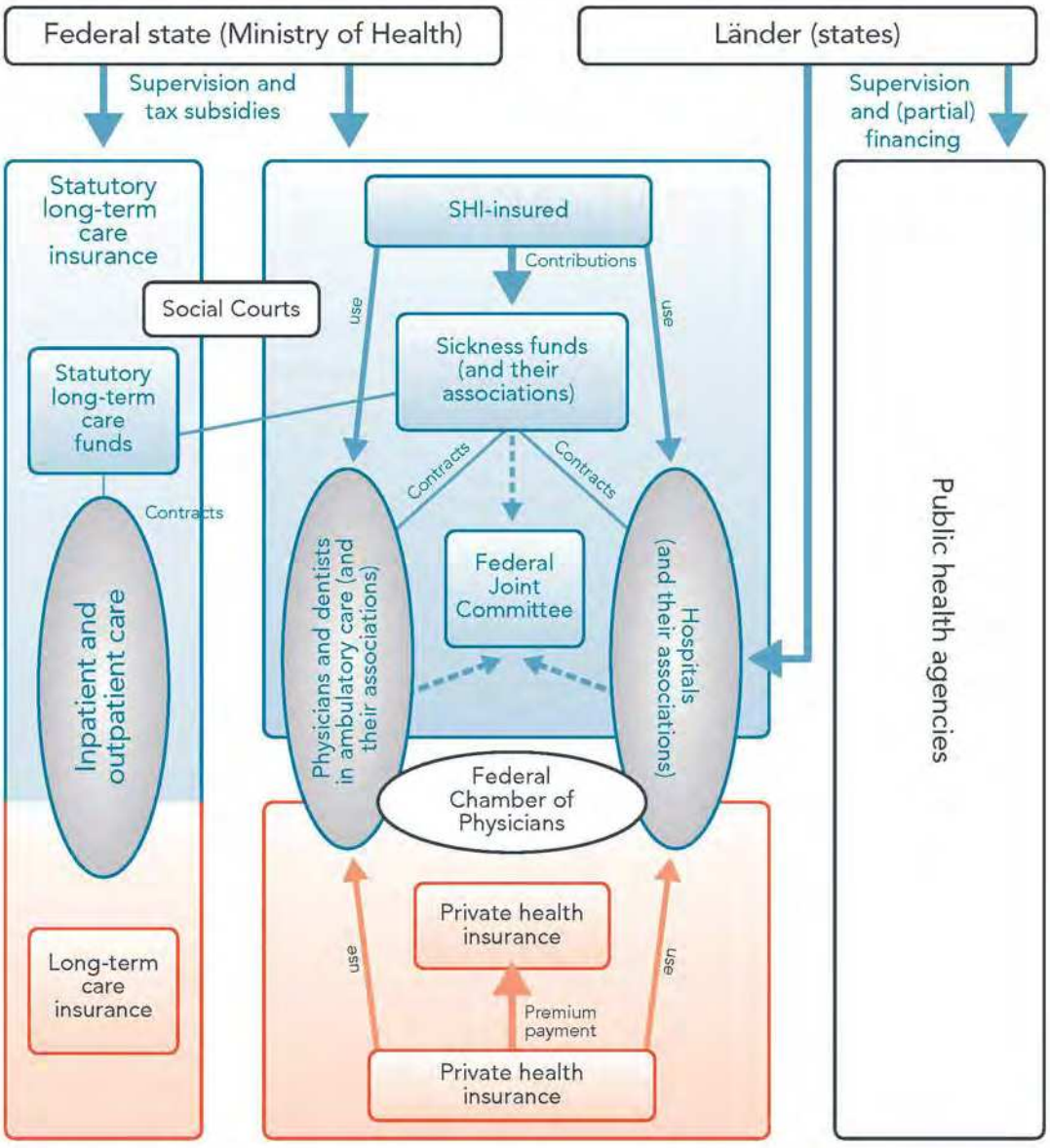

Source: Adapted from R. Busse and M. Blümel, "Germany: Health System Review," *Health Systems in Transition*, vol. 16, no. 2, 2014, p. 20.

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management system, by the stipulation that all physicians continue their medical education, and by health technology assessments for drugs and procedures. However, there is no revalidation requirement for physicians. Hospital accreditation is voluntary.

All new diagnostic and therapeutic procedures applied in ambulatory care must be positively evaluated in terms of benefits and efficiency before they can be reimbursed by sickness funds. Volume thresholds have been introduced for a number of complex procedures (e.g., transplantations), requiring a minimum number of such procedures for hospitals to be reimbursed. Process and (partly) outcome quality are addressed through the mandatory quality reporting system for the roughly 2,000 acute-care hospitals. The recently passed Hospital Care Structure Reform Act will provide a focus on quality-related hospital accreditation and payment, beginning in 2016 (see section on reforms).

Disease management programs are modeled on evidence-based treatment recommendations, with mandatory documentation and quality assurance. Nonbinding clinical guidelines are produced by the Physicians' Agency for Quality in Medicine and by professional societies.

All hospitals are required to publish results on selected indicators defined by the Federal Office for Quality Assurance and, until 2015, the AQUA Institute, allowing for hospital comparisons.

Many institutions and health service providers include complaint management systems as part of their quality management programs; in 2013, such systems were made obligatory for hospitals. At the state level, professional providers' organizations are urged to establish complaint systems and arbitration boards for the extrajudicial resolution of medical malpractice claims.

To strengthen quality by law, in addition to the above, government commissioned the Federal Joint Committee in 2015 to establish the Institute for Quality and Transparency in Health Care, replacing the AQUA Institute. The institute is operational from January 2016, with the task of developing further indicators for quality assurance, which might provide an additional criterion for decisions on hospital planning and payment.

The Robert Koch Institute, an agency subordinate to the Federal Ministry of Health and responsible for the control of infectious diseases and health reporting, has conducted national patient surveys and published epidemiological, public health, and health care data. Disease registries for specific diseases, such as certain cancers, are usually organized regionally. In August 2013, as part of the National Cancer Plan, the federal government passed a bill that proposes the implementation of a nationwide standardized cancer registry in 2018 to improve the quality of cancer care.

What is being done to reduce disparities?

Strategies to reduce health disparities are delegated mainly to public health services, and the levels at which they are carried out differ between states. Health disparities are implicitly mentioned in the national health targets. A network of 53 health-related institutions (e.g., sickness funds and their associations) promotes the health of the socially deprived (Cooperative Alliance National Health Targets, 2015). Primary prevention is mandatory by law for sickness funds; detailed regulations are delegated to the Federal Association of Sickness Funds, which has developed guidelines regarding need, target groups, and access, as well as procedure and methods. Sickness funds support 22,000 health-related programs, e.g., in nurseries and schools (Federal Association of Sickness Funds, 2015). With the Act to Strengthen Health Promotion and Prevention, these programs will be further developed and financially supported (see below).

The Health Monitor (*Gesundheitsmonitor)* is a national association of nonprofit organizations and sickness funds. To assess access to health care, it regularly conducts studies from the patient perspective, for example, on the level of information, experiences with health care, or evaluation of health system reforms.

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What is being done to promote delivery system integration and care coordination?

Many efforts to improve care coordination have been implemented, e.g., sickness funds offer integrated-care contracts and disease management programs for chronic illnesses to improve care for chronically ill patients and to improve coordination among providers in the ambulatory sector. In December 2014, 9,917 registered disease management programs for six indications had enrolled about 6.5 million patients (more than 8% of all the SHI-insured). There is no pooling of funding streams between the health and social care sectors.

From 2016, the Innovation Fund will promote new forms of cross-sectoral and integrated care (also for vulnerable groups) supported by annual funding of EUR300 million, or USD381 million (including EUR75 million, or USD95 million, for evaluation and health services research). Funds will be awarded through an application process overseen by an Innovation Committee based at the Federal Joint Committee.

What is the status of electronic health records?

About 90 percent of physicians in private practice use electronic health records (EHRs) to help with billing, documentation, tracking of laboratory data, and quality assurance. The use of online services to transmit billing information and documentation from disease management programs is obligatory. Hospitals have implemented EHRs to varying degrees. Unique patient identifiers do not exist and interoperability is limited, as data safety concerns represent a significant obstacle.

As of 2015, electronic medical chip cards are used nationwide by all the SHI-insured; they encode information as to the person's name, address, date of birth, and sickness fund, along with details of insurance coverage and the person's status regarding supplementary charges (Company for Telematics Applications for the Electronic Health Card, 2015). In 2015, the Federal Cabinet proposed a bill for secure digital communication and health care applications (E-Health Act), which provides concrete deadlines for implementing infrastructure and electronic applications, and introduces incentives and sanctions if schedules are not adhered to. SHI physicians will receive additional fees for transmitting electronic medical reports (2016–17), collecting and documenting emergency records (from 2018), and managing and reviewing basic insurance claims data online. From July 2018, SHI physicians who do not participate in the online review of the basic insurance claims data will receive reduced remuneration. Furthermore, in order to ensure greater safety in drug therapy, patients who use at least three prescribed drugs simultaneously will receive an individualized medication plan, starting in October 2016. In the medium term, this medication plan will be included in the electronic medical record (Federal Ministry of Health, 2015).

How are costs contained?

All drugs, both patented and generic, are placed into groups with a reference price serving as a maximum level for reimbursement, unless they can demonstrate added medical benefit. Drug companies are required to produce scientific dossiers for all new drugs demonstrating added medical benefit, which is then evaluated by IQWiG, followed by a Federal Joint Committee decision within a six-month period. For drugs with added benefit, the Federal Association of Sickness Funds negotiates a rebate on the manufacturer's price that is applied to all patients. In addition, rebates are negotiated between individual sickness funds and pharmaceutical manufacturers to lower prices below the reference price.

Recently, reliance on overall budgets for ambulatory physicians and hospitals and on collective regional prescription caps for physicians has been replaced by an emphasis on quality and efficiency. The Hospital Care Structure Reform Act aims not only to link hospital payments to good service quality, but also to reduce payments in the case of "low value."

To extend competition, some purchasing powers have been handed over to the sickness funds, e.g., to contract providers selectively within an integrated care contract or to negotiate rebates with pharmaceutical companies.

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What major innovations and reforms have been introduced?

In June 2015, parliament passed the Act to Strengthen SHI Health Care Provision. This act is based on the 2011 SHI Care Structures Act, and takes measures to further strengthen service provision structures for SHI patients, particularly in underserved rural areas. These measures include a right for municipalities to establish medical treatment centers, a ban on transferring SHI-accredited practices to successors in overserved areas, the establishment of appointment service centers that would guarantee a specialist appointment within four weeks, and the promotion of innovative forms of care, especially through the establishment of an Innovation Fund at the Federal Joint Committee endowed with EUR300 million (USD381 million) annually from 2016 to 2019 (Health Systems and Policy Monitor, 2015).

The Act to Strengthen Health Promotion and Prevention passed parliament in July 2015. In an upcoming National Prevention Conference, the social security schemes, in collaboration with federal, state, and local governments, as well as the Federal Employment Agency, will agree on common goals and approaches. Furthermore, the act aims to improve prevention and health promotion by regulating vaccination policy and by expanding health checkups. Sickness funds and long-term care funds invest EUR500 million (USD635 million) annually, of which about EUR300 million is earmarked for health promotion in children's day-care facilities, schools, the work environment, and long-term care facilities (Federal Ministry of Health, 2015).

The Hospital Care Structure Reform Act comes into force in January 2016. The law provides for the introduction of quality aspects in hospital planning (legally defined minimum volumes) and payment (quality-related supplements and reductions), as well as a more patient-friendly design for hospital reports. In order to strengthen nursing care of patients and to create new nursing jobs, a subsidy program will provide up to EUR660 million (USD839 million) in 2016–2018, and, starting in 2019, EUR330 million (USD419 million) per year. Hospital financing will be developed further and the reallocation pool will earmark EUR500 million to support measures to improve hospital care structures (Federal Ministry of Health, 2015).

Several other bills are pending in the legislative process, e.g., the E-Health Act (see section on EHR) and the Hospice and Palliative Care Act (see section on long-term care and social supports).

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The Indian Health Care System, 2015

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What is the role of government?

The constitution of India considers the "right to life" to be fundamental and obliges government to ensure the "right to health" for all, without any discrimination (MOH, 2009; Thomas, 2009). More recently, the National Health Bill, introduced in 2009, views health care as a public good and health as a human right of every individual (MOH, 2009). The goal of India's national health policy is universal access to good-quality health care services without financial hardship (MOH, 2014).

Under the constitution, areas of public policy are divided between the central and state governments. States are responsible for organizing and delivering health services to their population. The central government, meanwhile, plays an important role with respect to international treaties, medical education, prevention of food adulteration, quality control in drug manufacturing, national disease control, and family planning programs. It also carries out a stewardship role with respect to policymaking, developing the regulatory framework, and supporting the work of the states.

At the local level, *Panchayati Raj* institutions (PRIs)—a decentralized system of local governance formalized in 1992—and their elected representatives participate in the functioning of district and subdistrict institutions through various committees (MOH, 2014).

Who is covered and how is insurance financed?

Publicly financed health insurance: In spite of strong economic growth, total expenditures on health represent 4.1 percent of GDP (MOH, 2014). Of total health expenditures, 71.6 percent were financed by private funds and 26.7 percent by public funds, including central, state, and local government bodies and external flows (CBHI, 2013). Per capita health spending has risen from USD21 in 2000 to USD44 in 2009 (WHO, 2015). The 12th five-year plan (2012–17) aims to increase public spending to 2 percent of GDP (MOH, 2011).

In principle, coverage of health services is universal and available to all citizens under the tax-financed public system. In the draft national policy document, it is proposed that tax-based financing remain the major source of funding for the 70 percent of the population who are poor. Free primary care provided by the public sector, supplemented by strategic purchase of secondary and tertiary care services from both the public and private sectors, would be the main financing approach (MOH, 2014).

However, in practice, severe bottlenecks in accessing government health care services compel households to seek private care, often resulting in high out-of-pocket payments.

In addition to public health facilities, a number of health insurance schemes currently exist in India. The central government's health services for civil servants and state-level employee insurance for formal workers are mandatory schemes. More recently, a number of social health initiatives, like *Rashtriya Swasthya Bima Yojana* (RSBY), have been launched to broaden health care access, mainly for the poor. These have enrolled 36 million people, expanding coverage from 5 percent to 15 percent over a six-year period (RSBY, 2015). With proposed expansion of the RSBY scheme to include rickshaw and taxi drivers, rag pickers, sanitation workers, domestic workers, street vendors, building and construction workers, and beedi (tobacco) workers, coverage under the scheme is expected to increase further (RSBY, 2015). Given these trends, a World Bank study projects that by 2015, about half the country's population could be covered with some form of health insurance (Forgia and Nagpal, 2012).

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Private health insurance: The majority of private expenditures are out-of-pocket payments made mainly at the point of service, and less than 5 percent are financed by voluntary health insurance (VHI). Despite tax exemptions for insurance premiums, only upper-class urban populations are able to afford VHI, which serves as a substitute for government health services. Given India's expanding middle class, low VHI penetration is surprising. It appears that in the coming years, the private insurance industry, which is still in its infancy, has the potential to expand.

What is covered?

Services: Covered services, some of which require copayments (see below), include preventive and primary care, diagnostic services, and outpatient and inpatient hospital care. Medications on the essential drug list are free (if and when available), while other prescription drugs are purchased from private pharmacies.

Services available through the national health programs are free to all. India has one of the world's largest publicly financed HIV drug programs, and all drugs and diagnostic services for vector-borne diseases, such as dengue fever and malaria, are free, as are insecticide-treated bed nets for malaria control. Immunizations and maternal and child health (MCH) services are free as well (MOH, 2014).

Under the National Rural Health Mission, public health institutions in rural areas are being upgraded to meet the benchmarks for quality laid down by the Indian Public Health Standards (IPHS) (MOH 2013), which specify essential and desirable services that must be available in each type of health care facility. For example, at primary health centers these include outpatient services; emergency care provided mainly by nursing staff; referral and inpatient services; MCH-related services; school health and adolescent health services; care for noncommunicable diseases; basic laboratory services; linkages with secondary care providers and community health centers; basic surgical procedures; and medications on the state essential drug list and those required under national programs. The standards also cover necessary infrastructure and human resources. In practice, however, the availability of staff, equipment, and drugs varies significantly between and within states.

Cost-sharing and out-of-pocket spending: Most states have some user charges for outpatient visits, hospital admission, diagnostic and prescription drugs, though there is huge variation in fee policies among the states. More than 70 percent of total health expenditures are financed through user fees, and most out-of-pocket spending is for hospital admissions. Nearly all admission, even to public hospitals, lead to catastrophic health expenditures, and over 63 million people are faced with impoverishment every year because of health care costs. In 2011–12, out-of-pocket spending on health care as a share of total monthly household spending per capita was 6.9 percent in rural areas and 5.5 percent in urban areas (MOH, 2014).

Under the National Rural Health Mission, free treatment in public hospitals, as part of the *Janani Suraksha Yojana*,[1] was extended to maternity, newborn, and infant care and to control of tuberculosis, malaria, and HIV/AIDS. For all other services, user fees continue to apply, especially for diagnostics and drugs excluded from the state's essential drug list (MOH, 2014).

Safety nets: Safety nets for the poor and other vulnerable groups are provided by a number of government-funded health insurance schemes that have been introduced in recent years. These are intended to improve access to hospitals and reduce out-of-pocket payments. Some states finance hospital care through health insurance programs. The RSBY (see above) protects mostly those below the poverty level.[2] Evaluations of such schemes show improved utilization of hospital services (mainly private), especially among the poorest 20 percent of households (MOH, 2014).

[1] Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission with the objective of reducing maternal and neonatal mortality through the promotion of institutional delivery among poor pregnant women.

[2] Defined as monthly per capita consumption expenditure of INR972 (USD55) in rural areas and INR1,407 (USD79.50) in urban areas. Please note that, throughout this profile, all figures in USD were converted from INR at a rate of INR17.7 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for India. The poverty ratio at the all-India level is 29.5 percent (Planning Commission, 2014).

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Another program, designed to reduce maternal mortality, is *Janani Shishu Suraksha Karyakarm*, launched in 2011 and currently implemented all over India. It entitles all pregnant women to free delivery, including by caesarean section, in public health institutions. Women receive free food, drugs, and consumables, as well as free diagnostics. Free transportation is also provided. Similar entitlements are available for all sick infants (up to age 1) at public health facilities (MOH, 2015a).

How is the delivery system organized and financed?

The average number of patients seen by a registered doctor and nurse is 1,212 and 532, respectively (WHO, 2013). This implies an average of 0.7 doctors and 1.1 nurses per 1,000 population, compared with 3.2 and 8.8, respectively, in countries within the Organisation for Economic Co-operation and Development (OECD, 2014). Although India has a much younger population than OECD countries, this acute shortage of providers is a major constraint as India moves toward universal coverage.

Health care services are delivered by a complex network of public and private providers, ranging from single doctors to specialty and "super-specialty" tertiary care corporate hospitals. The government health care system is designed as a three-tier structure comprising primary, secondary, and tertiary facilities.

Primary care: Facilities at the primary level include: subcenters (SCs), for a population of 3,000 to 5,000; primary health centers (PHCs), for 20,000 to 30,000 people; and community health centers (CHCs), which serve as referral centers for every four PHCs, covering 80,000 to 120,000. Primary health centers (PHCs) are the cornerstone of rural health services, serving as a first "port of call" to a qualified doctor in the public health sector and providing a range of preventive, promotive, and curative health services. On average, they have about six beds for inpatient admission. In 2012, there were 148,366 SCs, 24,049 PHCs, and 4,833 CHCs (CBHI, 2013). Availability of staff in these primary care facilities is a major concern. For example, specialist shortage at CHCs is nearly 70 percent (CBHI, 2013).

Primary care doctors working in the public sector are employed by local governments and paid salaries. No registration is required, and patients generally go to the nearest PHC located in their geographical area. There are a number of other staff at PHCs, among them auxiliary nurse-midwives, pharmacists, and lab technicians—all on salary. Normally, there is limited scope for primary care doctors to earn additional income via incentives. Although government doctors in most states are banned from private practice, officials find it is difficult to monitor and take action against offending doctors.

In the private sector, an array of services is provided, in both urban and rural areas, by solo practices ranging from unregistered "quacks" to registered medical practitioners to small nursing homes and poly clinics. There are estimates that as much as 40 percent of private care is provided by unqualified providers (MOH, 2014). Patients pay out-of-pocket for the services received. There are no fee schedules.

Outpatient specialist care: In government health facilities, salaried, full-time specialists are located at CHCs and district hospitals. Usually, choice is limited in rural areas. These specialists are not permitted to work in private practice in most states. In the private sector, there is a huge choice of specialists, especially in urban areas. Consultation fees vary, as there is no fixed fee schedule, and they operate from their own clinics, hospitals, or poly clinics, or from speciality hospitals. Private specialists are commonly visited by upper- and middle-class urban residents.

Administrative mechanisms for direct patient payments to providers: There are no direct payments in public health facilities and most government-sponsored insurance programs. In the private sector, patients usually pay directly out-of-pocket. Only in a small percentage of cases where patients have VHI is payment made up front and claims submitted to the insurer for reimbursement.

After-hours care: All PHCs are expected to provide basic emergency services (mainly by nursing staff), and all CHCs are equipped to provide emergency services around-the-clock. Primary care doctors are required to

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provide after-hour care, reimbursement for which is built into their salaries. A free medical help line is being operated by certain states in India.

Hospitals: District hospitals function as the secondary tier of public providers for the rural population (MOH, 2011). The average population served per public bed is 1,946. Of a total of 628,708 government beds, 196,182 are in rural areas (CBHI, 2013). Government hospitals operate within a yearly budget allocation.

There has been a major expansion of the private hospital sector recently, and government-sponsored health schemes rely on private hospitals as a part of public–private partnerships. Between 2002 and 2010, the private sector created more than 70 percent of new beds, contributing 63 percent of total hospital beds (Gudwani et al., 2012). The private sector currently provides about 80 percent of outpatient care and 60 percent of inpatient care (MOH, 2014). In addition, about 80 percent of doctors, 26 percent of nurses, and 49 percent of beds are in the private sector (Wennerholm et al., 2013).

Private-sector hospitals range from small, family-run general hospitals to facilities providing super-speciality tertiary care. Until the 1980s, private-sector hospitals were mainly run by charitable trusts and registered as not-for-profit. With India's economic liberalization, a growing middle class, and the rise in medical tourism, a number of corporate hospitals have been established, and for-profit private hospitals are becoming more common. There also has been a considerable expansion in tertiary care service providers in recent years, mostly in the private sector. The need for tertiary care is growing, but the costs are growing even faster and have become prohibitive (MOH, 2014).

Physician payment in the private sector varies from salary to fee-for-service. Hospitals that pay doctors a fixed salary do have incentives for attracting new patients but provide no incentives for internal referrals within the hospital.

Mental health care: Mental health is one of the most neglected areas of India's health system. India has less than 21 percent of the psychiatrists its population needs and less than 2 percent of clinical psychologists and social workers required (CBHI, 2013).

Attempts are being made to rectify the situation. For example, the Mental Health Care Bill of 2013 makes access to mental health care a right for every person. Access at government health facilities must be affordable, of good quality, and provided without discrimination. Recently, under the National Mental Health Programme (NMHP), a mass media campaign on creating awareness and reducing stigma was undertaken. To address the gap in mental health resources and increase training capacity, 10 centers of excellence and 23 postgraduate departments in mental health specialties have been established across the country (MOH, 2011).

According to the IPHS guidelines under NMHP, primary health centers should ensure early identification (diagnosis) and treatment of common mental disorders such as psychosis, depression, anxiety disorders, and epilepsy, as well as referral services. It is also essential that PHCs provide information, education, and communication on prevention, stigma removal, and early detection of mental disorders. However, given capacity constraints, it remains to be seen to what extent these steps are implemented.

Long-term care and social supports: Despite the growing elderly population, there has been a lack of long-term care services. Families have mainly been responsible for providing necessary care. Recently, the central government launched the National Programme for Health Care of the Elderly to address the health-related problems of elderly people (MOH, 2015a; DGHS, 2011). This is intended to provide additional human resources and funding for home care, screening for early diagnosis, vaccinations for high-risk groups, and health education for caregivers.

Examples of social welfare support provided to the elderly include old-age pensions, subsidized food and transport, lower income tax, and higher savings interest rates. Benefits under certain schemes for the elderly, such as the old-age pension scheme and the public distribution system, are available to those below the poverty level.

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Given increasing life expectancy, an expanding middle class, and technological advances, there has been growing interest in the private sector in providing home care for the elderly.

What are the key entities for health system governance?

Public actors in the Indian health care system include the Ministry of Health and Family Welfare, state governments, and municipal and local level bodies. The ministry consists of the Department of Health and Family Welfare and Department of Health Research (MOH, 2015a). Despite the existence of the latter, there is very little evidence that comparative research and cost-effectiveness studies are used in policy formation.

The Directorate General of Health Services, an attached office of the Department of Health and Family Welfare, provides technical advice and is involved in the implementation of health schemes. In 2014, the new Ministry of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy was formed. In addition, health care services

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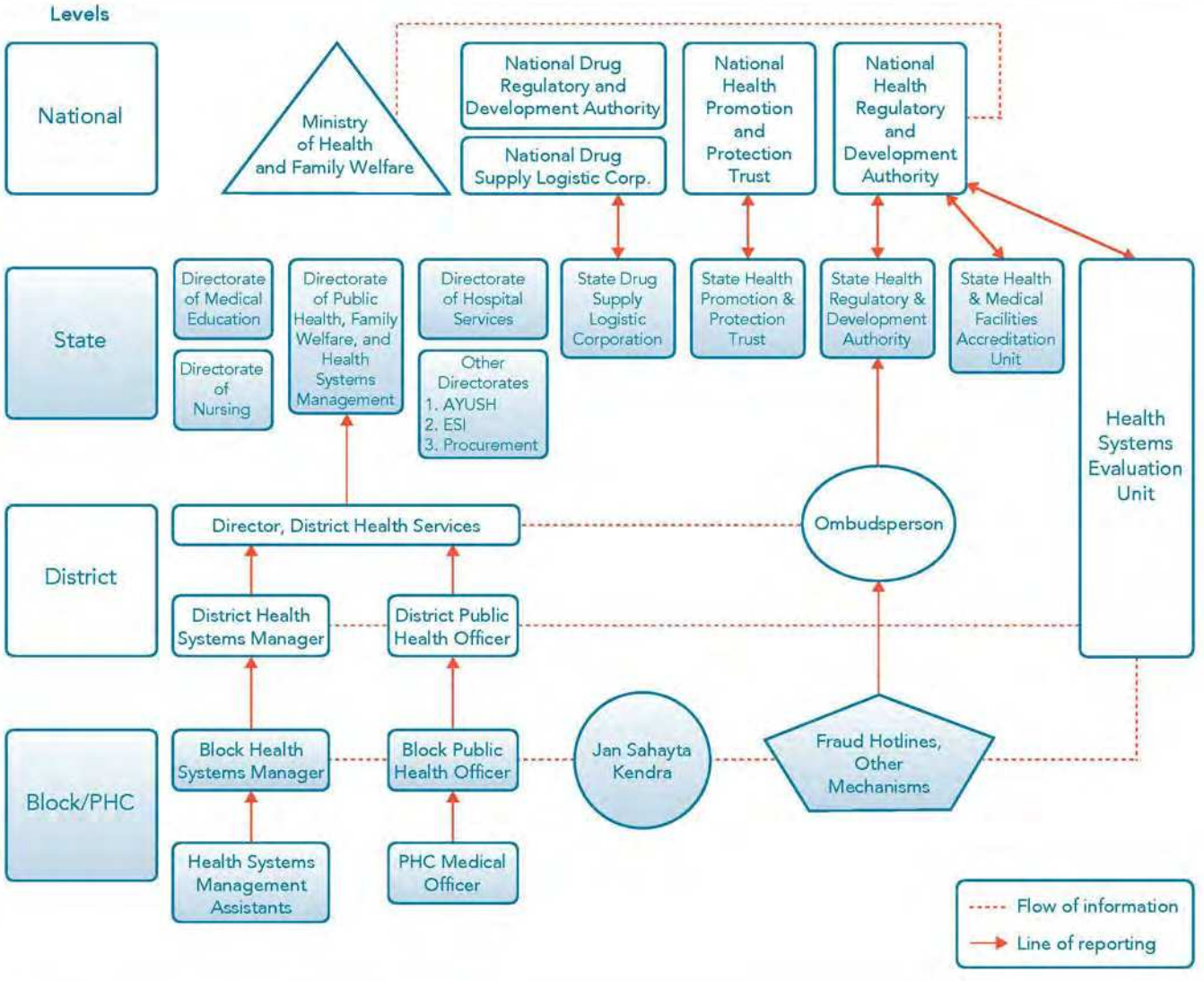

Source: Planning Commission of India, 2011.

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are provided by other ministries and departments to their personnel (e.g., defense, railways, ports, mines, and employee state insurance schemes).

Each state has its own State Directorate of Health Services and State Department of Health and Family Welfare, which is responsible for providing care to its population. District-level health services provide a link between each state and primary care services.

Other agencies involved in health system governance include the Insurance Regulatory and Development Authority, which regulates the health insurance industry, and the National eHealth Authority, which is to become the nodal authority for development of an integrated health information system (MOH, 2015b). There is confusion in India with respect to which entities are responsible for regulating the private sector and for ensuring quality of care, as there are multiple agencies under different ministries, with no single responsible agency. For example, the Bureau of Indian Standards and Consumer Protection Act are under the Ministry of Consumer Affairs, whereas the Quality Council of India is under the Ministry of Commerce and Industry. An attempt is being made to bring these agencies under one authority.

What are the major strategies to ensure quality of care?

Over the years, several regulations have been enacted and authorities created at the state and national level with the aim of protecting patients and improving quality of care. For example, at the state level, the Nursing Home Act and State Drug Controllers ensure quality of care provided by the private sector. A major impetus to establishing patient rights was the inclusion of private medical practice under the Consumer Protection Act in 1986 (Balarajan et al. 2011). To ensure quality of care and define standards for health facilities, a number of laws were introduced, including those creating a national accreditation system, the National Accreditation Board for Hospitals (NABH, 2006; Gyani, 2015), and the Indian Public Health Standards (IPHS, 1997) for primary and secondary health care services. In addition, many hospitals undergo accreditation and certification from international bodies such as the Joint Commission International (JCI) and the International Organization for Standardization (Wennerholm et al. 2013).

The Health Management Information System was launched in 2008 to monitor health programs and provide key inputs for monitoring and policy formulation. Currently, about 633 of 667 districts report data by facility (MOH, 2015a). Large-scale surveys like the National Family Health Survey, the District-Level Household Survey, and the Annual Health Survey are periodically undertaken at the district, state, and national levels. In addition, the Indian Council of Medical Research (ICMR) maintains disease registries for cancer, diabetes, cardiovascular diseases, and other illnesses.

The 2010 Clinical Establishments (Registration and Regulation) Act calls for prescribing minimum standards for all public and private clinical establishments in the country (MOH, 2012; MOH, 2015c). The act has already come into force in certain states (e.g., Arunachal Pradesh, Himachal Pradesh, Mizoram and Sikkim) and in all union territories (CBHI, 2013). In addition, facilities shall charge rates as determined by central government in consultation with the state. The act stipulates fines and penalties if provisions are breached by any facility. A national council for clinical establishment will oversee implementation and compliance at the national level. Similar councils at the state and district levels will be established to enforce compliance locally (MOH, 2015c).

Currently, a shift to one comprehensive approach of quality assurance is envisaged to replace the existing fragmented approach. For public health care facilities, the strategy would ensure that every facility is measured and scored for quality, and certified and incentivized when it achieves a certain minimum score. Quality measures would include clinical quality as well as patient safety, comfort, and satisfaction. In the private sector, voluntary accreditation with certificates like that of National Accreditation Board for Hospitals and National Accreditation Board for Testing and Calibration Laboratories would predominate. For private facilities that are part of a public–private partnership, quality certification would be mandatory either through those boards or through the public system (MOH, 2014).

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To ensure quality of medical education, a common national entrance exam is being debated. A licentiate exam will be introduced for all medical graduates, with renewal at periodic intervals (MOH, 2014).

Although there has been some progress made and new legislation introduced, progress in government regulation has been slow and implementation challenging (MOH, 2014; Gudwani et al., 2012), and there is no single government authority responsible to ensure quality of care (Wennerholm, 2013). Although the Clinical Establishments (Registration and Regulation) Act is one of the most important, far-reaching pieces of public health legislation enacted to date, its effective and uniform implementation in each state remains to be seen.

What is being done to reduce disparities?

Significant inequalities with respect to health care access and health outcomes exist between states, rural and urban areas, socioeconomic groups, castes, and genders. For example, the infant mortality rate is 48 per 1,000 live births in rural areas, while it is 29 in urban areas (Save the Children, 2013). With respect to access, it is estimated that the urban rich obtain 50 percent more health services than the average Indian citizen (Gudwani et al., 2012). And the number of government hospital beds per population in urban areas is more than twice the number in rural areas (Balarajan et al., 2011), and urban areas have four times more health workers per population (Planning Commission of India, 2011).

Recognizing the lack of a comprehensive national health care system as an important factor in health inequalities, the government views universal coverage through the National Health Mission as the main strategy to address the problem, along with a strengthening of the primary health care infrastructure in both rural and urban areas.

While there is no single agency responsible for ensuring that health inequalities are reduced, a number of new initiatives have been launched on behalf of low socioeconomic groups and other vulnerable populations. For example, with respect to maternal care, there is the Janani Suraksha Yojana, which provides mothers with cash incentives for institutional delivery, transportation in case of emergency, and additional incentives for accredited social health activists. Another initiative is expanding the use of information and communication technology in an attempt to increase rural Indians' access to health services.

Broadly, there is growing recognition about the need to address the growing burden of noncommunicable diseases, which are responsible for two-thirds of the total morbidity burden and just over half of deaths (WHO, 2015). Starting in 2013–14, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes is being implemented in 35 states and union territories (MOH, 2015a). It must be emphasised, however, that the effort against these diseases is still in its initial stages.

What is the status of electronic health records?

The establishment of a composite health information system (HIS) is proposed in the government's 12th five-year plan. The HIS will be based on adoption of national electronic health record standards, linked systems at the state and national levels, issuance of a unique health card to every citizen, and creation of a national health information center (MOH, 2015a).

States can develop systems to suit their needs and priorities, as long as they are consistent with standards set by the new National eHealth Authority (NeHA). NeHA will be the nodal authority responsible for development of the HIS and for enforcing the laws and regulations relating to privacy and security of patient health information and records (MOH, 2015b).

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How are costs contained?

There are no comprehensive policies to hold down costs. Most cost-containment strategies are limited to cost-sharing and use of generic drugs. There is limited evidence with respect to use of cost-effectiveness assessments, monitoring for financial performance, improvement in operational efficiency, and health technology assessments.

As the public health care system is financed through taxes, costs are contained in the first instance by allocations made to the health sector, which currently amount to less than 2 percent of GDP. Most government health facilities have to operate within the yearly allocated budget. Where there are public–private partnerships, government negotiates prices with private providers and reimburses accordingly.

What major innovations and reforms have been introduced?

A key goal of the 12th five-year plan is to move toward universal coverage to provide universal access to equitable, affordable, and quality health care, with supplementation from the private sector (MOH, 2014 and 2015a). Toward this end, the National Health Mission and its two Sub-Missions—the National Rural Health Mission and the National Urban Health Mission—was approved by the Cabinet in May 2013. The main components include health system strengthening in rural and urban areas; the Reproductive, Maternal, Newborn, Child and Adolescent Health strategy; and control of communicable and noncommunicable diseases (MOH, 2015a).

A number of initiatives are being introduced with respect to quality of care, as described in the section on quality, above.

An example of health system integration reform is the RSBY scheme. This scheme, now under the Ministry of Health and Family Welfare, is helping the state and central ministry move to a tax-financed, single-payer system (MOH, 2014).

Reforms also have been introduced to ensure equity in resource allocation. Allocation decisions are to take into account financial ability, developmental need, and high-priority districts, targeting specific population subgroups, geographical areas, health care services, and gender-related issues. A risk equalization formula based on health care need could be developed, with built-in financial incentives for facilities providing a certified quality of care (MOH, 2014).

Other initiatives being introduced include the India Newborn Action Plan, to reduce preventable newborn deaths and stillbirths; the provision of providing free drugs and diagnostic services; the aforementioned National eHealth Authority; and a new health rights bill to ensure health as a fundamental right (MOH, 2015a).

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The Israeli Health Care System, 2015

BRUCE ROSEN
MYERS-JDC-BROOKDALE INSTITUTE



What is the role of government?

Government, through the Ministry of Health, is responsible for population health and the overall functioning of the health care system. It also owns and operates a large network of maternal and child health centers, about half of the nation's acute care bed capacity, and about 80 percent of its psychiatric bed capacity (Rosen, Waitzberg and Merkur, forthcoming).

In 1995, Israel passed a national health insurance (NHI) law, which provides for universal coverage. In addition to financing insurance, government also provides financing for the public health service, and is active in areas such as control of communicable diseases, screening, health promotion and education, and environmental health, as well as providing various other services provided directly by the government. It is also actively involved in financial and quality regulation of key health system actors, including health plans, hospitals, health care professionals, and others.

Who is covered and how is insurance financed?

In 2013, national health expenditures accounted for 7.6 percent of GDP, of which about 60 percent are publicly financed.

Publicly financed health insurance: Israel's NHI system automatically covers all citizens and permanent residents. It is funded primarily through a combination of a special income-related health tax and general government revenues, which in turn are funded primarily through progressive income-related sources such as income tax.

Employers are required to enroll any foreign workers (whether documented or undocumented) in private insurance programs, whose range of benefits is similar to that of NHI. Private insurance is also available, on an optional basis, for tourists and business travelers.

Nevertheless, there are people living in Israel who do not have health insurance, including undocumented migrants who are not working. Several services are made available to all individuals irrespective of their legal or insured status. These include emergency care, preventive mother and child health services, and treatment of tuberculosis, HIV/AIDS, and other sexually transmitted infections.

Within the NHI framework, residents can choose among four competing, nonprofit health plans. Government distributes the NHI budget among the plans primarily through a capitation formula that takes into account sex, age, and geographic distribution. The health plans are then responsible for ensuring that their members have access to the NHI benefits package, as determined by government.

Private health insurance: Private voluntary health insurance (VHI) includes health plan VHI (HP-VHI), offered by each health plan to its members, and commercial VHI (C-VHI), offered by for-profit insurance companies to individuals or groups. In 2014, 87 percent of Israel's adult population had HP-VHI, and 53 percent had C-VHI (Brammli-Greenberg and Medina-Artom, 2015). C-VHI packages tend to be more comprehensive and more expensive than the HP-VHI packages. While C-VHI coverage is found among all population groups, coverage rates are highly correlated with income.

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Together, these two types of private VHI financed 14 percent of national health expenditures in 2012, a figure that has been increasing steadily. The Ministry of Health regulates HP-VHI programs, while the Commissioner of Insurance, who is part of the Ministry of Finance, regulates C-VHI programs. The focus of C-VHI regulation is actuarial solvency, with secondary attention to consumer protection more generally; in HP-VHI regulation, there is more attention to equity considerations and potential impacts on the health care system (Brammli-Greenberg, Waitzberg and Gross, 2015).

Reasons for purchasing VHI include securing coverage of services not covered by NHI (e.g. dental care, certain life-saving medications, institutional long-term care, and treatments abroad), care in private hospitals, or a premium level of service for services covered by NHI (e.g., choice of surgeon and reduction of waiting times). VHI coverage is also purchased as a result of a general lack of confidence in the NHI system's capacity to fully fund and deliver all services needed in cases of severe illnesses.

What is covered?

The mandated benefits package includes hospital, primary, and specialty care, prescription drugs, certain preventive services, mental health care, dental care for children, and other services. Dental care for adults, optometry, and home care are generally excluded, although the National Insurance Institute does provide some funding for home care, dependent on need. Limited palliative and hospice services are included in the NHI benefits package as well (Bentur et al., 2012).

Israel has a well-developed system for prioritizing coverage of new technologies within an annual overall budget set by the Cabinet (which includes Parliament members from the ruling parties) (Greenberg et al., 2009). Proposals for additions are solicited and received from pharmaceutical companies, medical specialty societies, and others. The Ministry of Health then assesses costs and benefits of the proposed additions, and a public commission combines the technical input with broader considerations to prepare a set of recommendations. These are usually adopted by the Minister of Health and subsequently by the Cabinet.

Cost-sharing and out-of-pocket spending: In 2012, out-of-pocket spending accounted for 26 percent of national health expenditures. Some of this was for services not included in the NHI benefits package, including dental care for adults, optical care, institutional long-term care (for those not eligible for means-tested assistance), certain medications, and medical equipment. The other major component was copayments for NHI services, such as pharmaceuticals, visits to specialists, and certain diagnostic tests. Dental care and pharmaceuticals are the two largest out-of-pocket components.

There are no copayments for primary care visits or for hospital admissions. There are also no quarterly or annual deductibles with NHI coverage. Within the NHI system, physicians are not allowed to balance-bill.

Safety net: There are a variety of safety-net mechanisms in place. For pharmaceuticals there is a quarterly ceiling for the chronically ill, and discounts for the elderly based on age, income, and health status. Holocaust survivors are exempt from copayments for pharmaceuticals. With regard to specialist visits, there are exemptions for elderly welfare recipients, children receiving disability payments, and people afflicted with certain severe diseases. There is a quarterly ceiling on total copayments for these visits at the household level, which is 50 percent lower for elderly people. In addition, people earning less than 60 percent of average wages pay a reduced health tax of 3 percent of income, instead of 5 percent.

How is the delivery system organized and financed?

Primary care: Nearly all Israeli primary care physicians (referred to as general practitioners (GPs) in this profile, although they also include board-certified family physicians) provide care through only one of the four competing nonprofit health plans, which vary markedly in how they organize care.

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In Clalit, the largest health plan, most primary care is provided in clinics owned and operated by the plan, and GPs are salaried employees. The typical clinic has three to six GPs, several nurses, pharmacists, and other professionals. Clalit also contracts with independent physicians; although these doctors tend to work in solo practices with limited on-site support from nonphysicians, they have access to various administrative and nursing services at Clalit district clinics.

The other three health plans also use of a mix of clinics and independent physicians in primary care, with the mix varying across plans. In Maccabi (the second-largest plan) and Meuhedet, almost all of the primary care is provided by independent physicians, while in Leumit the clinic model predominates (though not to the same extent as in Clalit).

Members of all plans can generally choose their GP from among those on the plan's list and can switch freely. In practice, nearly all patients remain with the same GP for extended periods.

In Clalit, each patient is registered with a GP who has responsibility for coordinating care and acts as gatekeeper, except for access to five common specialties. In Leumit, patients are registered with a clinic rather than a GP, while there is no registration in the other two plans. However, in all plans there is movement under way to associate each member with a physician for purposes of quality assurance and accountability. Clalit is the only plan with referral requirements to secondary care.

Independent physicians in all plans are paid on a capitation basis, with Clalit and Leumit using "passive capitation" (a quarterly, per member payment made irrespective of whether the member visited the GP in the relevant quarter) and Maccabi and Meuhedet using "active capitation" (where the payment is made only for members who visited their GP at least once during the quarter). Independent physicians also receive limited fee-for-service payments for certain procedures.

Plans monitor the care provided by their GPs and work closely with them to improve quality (Rosen et al., 2011). However, quality-related financial incentives are generally not used.

The salaries of Clalit clinic physicians are set via a collective bargaining agreement with the Israel Medical Association. The capitation rates of independent physicians, in all the health plans, are set by the plans in consultation with their physicians' associations.

It is estimated that of Israel's 24,000 physicians employed in 2011, approximately 7,000 worked with or for the health plans as GPs.

Outpatient specialty care: Outpatient specialty care is provided predominantly in community settings, either health plan clinics (the dominant mode in Clalit) or physician's offices (the dominant mode in the other health plans). The former tend to be integrated multispecialty clinics, while the latter tend to be single-specialty. Most specialists are paid on an active capitation basis, plus fee-for-service for certain procedures. Rates are set by the health plans and, within the NHI system, specialists may not balance-bill; patients pay the quarterly copayment only. Patients can choose from a list of specialists provided by their health plans. Specialists who work for the plans may also see private patients.

Administrative mechanisms for direct patient payments to providers: As noted above, the only direct payments to NHI providers are copayments. Patients can usually use their health plan membership cards instead of making cash payments; the provider receives the full fee from the health plans, which then collect the copayments from enrollees.

After-hours care: After-hours care is available via hospital emergency departments (EDs), freestanding walk-in "emergi-centers," and companies that provide physician home visits. Physicians providing care in EDs and emergi-centers come from a range of disciplines, including primary care, internal medicine, general surgery, orthopedics and, increasingly, emergency medicine. Nurses play a significant role in triage. They are typically salaried, while physicians working for home-visit companies are typically paid per visit.

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Primary care physicians are not required to provide after-hours care. They receive reports from the after-hours providers, and increasingly this information is conveyed electronically.

All the health plans operate national telephone advice lines for their members, which are nurse-staffed with physician backup.

Hospitals: Acute-care bed capacity is divided approximately as follows: government, 50 percent; Clalit, 30 percent; other nonprofits, 15 percent; for-profits, 5 percent (Haklai et al., 2014). However, the for-profits account for a much larger share of admissions and an even large share of surgical operations (Brammli-Greenberg and Artom, 2015).

Hospital outpatient care is reimbursed on a fee-for-service basis, and inpatient care is reimbursed using a mix of per diem and DRG arrangements, with approximately two-thirds of revenue coming from per diem payments (Brammli-Greenberg et al., forthcoming). Maximum rates are set by government, but health plans negotiate discounts. There are also revenue caps set by government, which limit the extent to which each hospital's total revenues can grow from year to year. Generally speaking, hospital payments include the cost of the physicians working for the hospitals.

In government and nonprofit hospitals, physicians are predominantly salaried employees, with limited arrangements for supplemental fee-for-service in some hospitals. Fee-for-service is the predominant payment mode in private hospitals.

Mental health care: Responsibility for the provision of mental health care was transferred in mid-2015 from the Ministry of Health to the health plans, which provide care through a mix of salaried professionals, contracted independent professionals, and services purchased from organizations (including the Ministry's mental health clinics). The benefits package is broad and includes psychotherapy, medications, and inpatient and outpatient care. Integration with primary care is currently limited, but this is expected to improve because of the transfer of responsibility to the health plans.

Long-term care and social supports: Financing of institutional long-term care is considered a responsibility of patients and their families, to the extent that they can afford it. An extensive system of needs-based, graduated subsidies is available from the Ministry of Health. These are generally paid directly to providers, although recently a change was made to the law to make it easier for families to receive cash subsides to be used in paying providers.

The health plans are responsible for medical care of the disabled elderly living in the community. In recent years, they have increased access to clinicians (particularly for the homebound) via home-care teams and telemedicine.

The National Insurance Institute finances personal care and housekeeping services for community-dwelling disabled elderly (Asiskovitch, 2013). Additional supports include an extensive network of day-care centers and a growing network of supportive neighborhoods.

For nursing homes, home medical care, and home aids, eligibility is based on inability to carry out activities of daily living. In addition, there are means tests for government assistance for nursing home and home aids, but not for medical home care provided by the health plans, or for any services provided through private insurance.

Private, for-profit providers deliver about two-thirds of nursing home care, virtually no medical home care (which is delivered by the private, nonprofit health plans), and nearly all home aids.

Although the government maintains that hospice care is included in the NHI benefits package that the health plans are supposed to provide, the plans dispute this. Some hospice care is available (particularly home hospice), though much less than is needed. Approximately half of the adult population has private long-term care insurance. There is no direct financial support for informal or family caregivers.

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What are the key entities for health system governance?

Parliament (the Knesset) adopts and amends legislation related to the health system. The Cabinet, comprising a selection of Knesset members from the ruling parties, has executive responsibility for the government as a whole, including the Ministry of Health (MoH). The MoH has overall responsibility for population health and the effective functioning of the health care system. It includes:

- The Minister, an elected member of the Knesset and typically also a member of the Cabinet. The Minister has full authority and responsibility for the functioning of the MoH.
- The Director-General, the MoH's top professional, who is appointed by the Minister to run the operations of the MoH.
- A large number of departments, including those responsible for quality and safety, assessing cost-effectiveness, fee-setting, public information, and health IT.
- Various advisory bodies, including the National Health Council, a public advisory; the benefits package committee, which advises on prioritization of new technologies for inclusion in the NHI benefits package; and national councils in such areas as trauma care, mental health, and women's health.

The Ministry of Health has an ombudsman's office to help citizens realize their rights under the NHI law. In addition, there are various nongovernmental patient advocacy organizations, many of which focus on particular diseases.

The Budget Division of the Ministry of Finance prepares the budgets of all ministries, including the MoH, for consideration by the Cabinet and then the Knesset. It also plays a major role in promoting and shaping major structural reforms to the health system and partners with the MoH on interministerial committees, such as those that set maximum hospital prices and the capitation formula. The Ministry of Finance Insurance and Capital Markets Division regulates commercial health insurers. The government also has an antitrust unit responsible for promoting competition, but it is not very active in the health area.

The Scientific Council of the Israel Medical Association is responsible for the specialty certification programs and examinations, in coordination with the MoH. The Council for Higher Education is responsible for the authorization, certification, and funding of all university degree programs, including those for training health care professionals.

What are the major strategies to ensure quality of care?

For over a decade, Israel has had a well-developed system for monitoring the quality of primary care. Comparative quality data for individual health plans has been made public since 2014 (Jaffe, 2012). While the published data relate to the health plans as a whole, the plans have internal data by region, clinic, and individual physician. The plans and their clinicians have made intensive use of this data to bring about substantial improvements in quality (Rosen et al., 2011; Balicer et al., 2015).

The MoH publishes comparative data on the quality of hospital care. This system is much newer than the system for primary care quality and is currently limited to a handful of indicators. However, it is expected to develop rapidly over the coming years.

The MoH is in the process of launching a national initiative to reduce waiting times for surgical procedures, and there are several initiatives focused on the care of particular diseases, such as dementia. The health plans are increasingly active in implementing programs for the chronically ill, including disease management.

Hospitals and clinics require a license from the MoH, granted only when basic quality standards are met. Hospitals are also increasingly seeking, and securing, accreditation from Joint Commission International.

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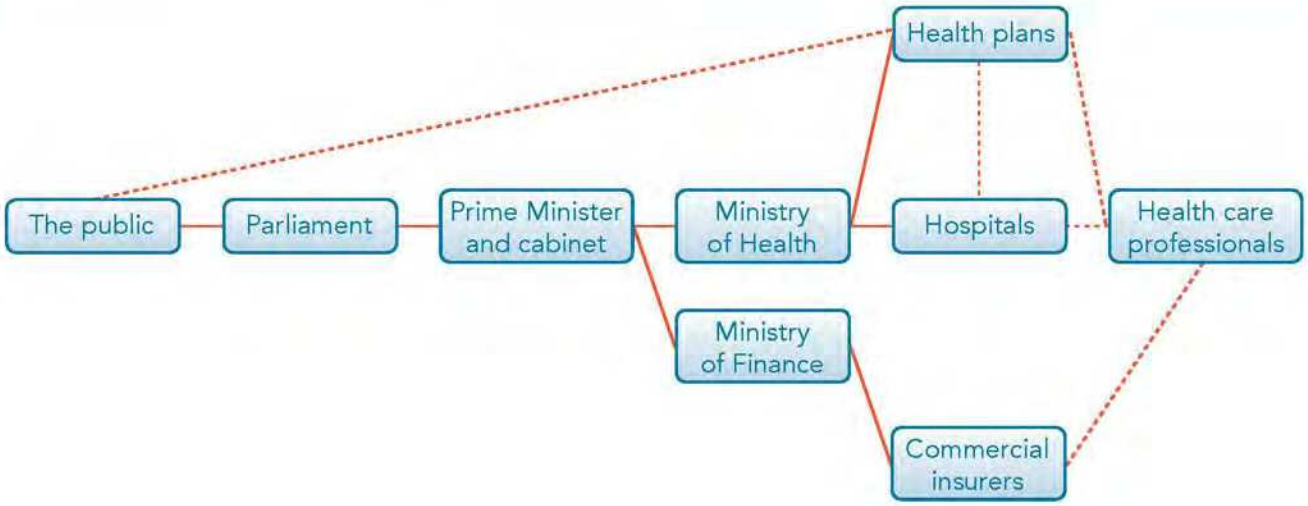
Organization of the Health System in Israel



Source: B. Rosen, Myers-JDC-Brookdale Institute, 2015.

There are biannual surveys of the general population regarding the service level provided by the health plans. The MoH recently launched an annual survey of hospitalized patients. Results are published by institution.

There are currently no explicit financial incentives for hospitals and health plans to improve quality. However, due to the competitive environment, public dissemination of quality data may be providing an indirect incentive. Consideration is being given to introducing a limited number of pay-for-performance incentives in the years ahead.

National registries are maintained by the MoH for certain expensive medical devices and for a broad range of diseases and conditions, including: cancer, low birth weight, trauma, and occupational diseases.

To receive a medical license from the MoH, persons who studied in an Israeli medical school must also successfully complete a one-year internship. Those who studied abroad are usually also required to pass an examination. Specialty recognition requires specialty training in an accredited program and passing an exam. The there are no re-licensure exams for physicians.

What is being done to reduce disparities?

The MoH is leading a major national effort to reduce disparities, in cooperation with the health plans and hospitals. Key initiatives include:

- Reducing financial barriers to care, particularly for low-income persons and other vulnerable populations. Most prominently, mental health care and dental care for children has been added to the NHI benefits package, thereby reducing the substantial financial barriers that existed when these services were provided privately (Rosen, 2012).
- Enhancing the availability of services and professionals in peripheral regions, by increasing the supply of beds and advanced equipment in the periphery and providing financial incentives for physicians to work in the periphery.

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- Addressing the unique needs of cultural and linguistic minorities, through adoption of cultural responsiveness requirements for all providers, establishment of a national translation call center, and targeted interventions for the Bedouin and other high-risk groups.
- Intersectoral efforts to address the social determinants of health and promote healthy lifestyles.
- Creation, analysis, and public dissemination of information about health care disparities, including periodic reporting of variations in health and health care access.

What is being done to promote delivery system integration and care coordination?

The health plans, which are both insurers and providers, are essentially the sole source of primary care and the main source of specialty care. This structural integration of services provides the foundation for provision of relatively seamless care for all the insured, including complex and chronically ill patients. The plans' health information systems link primary and specialty care providers, and a new national health information exchange is linking the health plans and the hospitals. Increasingly these provide access to electronic medical information at the point of care.

In addition, the health plans have put forth several targeted management programs that aim to provide comprehensive integrated care for complex patients with chronic conditions. These make extensive use of the plans' sophisticated information systems, videoconferencing, and other innovative techniques (Intel, 2015).

Generally speaking, integration is still limited among the various components of the long-term care system and between long-term care and other components of the health care system. However, this may change in the future if long-term care becomes a responsibility of the health plans (see below).

What is the status of electronic health records?

All health plans have electronic health record (EHR) systems that link all community-based providers—primary care physicians, specialists, laboratories, and pharmacies. All GPs work with an EHR. Hospitals are also computerized but are not fully integrated with health plan EHRs. The MoH leads a major national health information exchange project to create a system for sharing relevant information across all hospitals and health plans.

Each citizen has a unique identification number, which functions as a unique patient ID. Patients have the right to get copies of their medical records from hospitals and health plans, and patients can access some components of their EHR online, but the full records are not generally available. Efforts are under way to set up secure messaging systems linking patients and their GPs.

How are costs contained?

Israel is one of the most successful high-income countries in containing costs, with health expenditures remaining below 8 percent of GDP. Strategies include:

- Channeling the bulk of funding through a single, tightly controlled, government source
- Maintaining tight controls on key supply factors, such as hospital beds and expensive medical equipment
- Requiring the health plans—which function as the building blocks of the health system—to provide care competitively, within budgets that are largely determined prospectively
- Maintaining a well-developed system of community-based services, which reduces reliance on high-cost hospital care

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- Using electronic health records effectively, particularly in the community
- Purchasing pharmaceuticals in bulk and relying heavily on generics
- Setting maximum hospital reimbursement rates (government), negotiating discounts (health plans), and instituting hospital global revenue caps
- Explicitly prioritizing public funding for new technologies included in the NHI benefits package
- Aligning organizational and financial incentives between clinicians and the hospitals or health plans for whom they work (see below).

Although clinicians are rarely given explicit financial incentives to contain costs, reliance on salary and capitation (rather than fee-for-service) may reduce incentives to over-treat. Moreover, the health plans have various internal processes to discourage care that provides poor value.

Of recent concern to some experts, however, is the recent growth of private medical care and private financing, which is seen as potentially jeopardizing Israel's success in containing cost growth.

What major innovations and reforms have been introduced?

Mental health: In July 2015, mental health care was added to the set of services that the health plans must provide within the NHI framework, making access a legally guaranteed right rather than a government-supplied service whose availability is subject to budget constraints. Because of this new mandatory package of mental health services, government funding for health plans has been increased substantially to cover the additional costs. The main objectives of the reform are to improve the linkage between physical and mental care, increase the availability of mental health services, and increase efficiency. An external evaluation will ascertain the extent to which the objectives are achieved and whether various concerns are realized (Rosen et al., 2008).

Comparative data on hospital performance: In 2015, the MoH began publishing comparative data on hospital quality, and there are plans to rapidly expand the indicator set in the years ahead. In 2014, the Ministry published the results of a nationwide survey of hospitalized patients regarding their care experience. It is also assembling a database of waiting times for surgical operations, with the intention of publishing comparative data in 2016. The objectives of all these efforts are to provide hospitals with information to help identify problem areas, enhance consumer choice of hospitals, and provide hospitals with incentives to improve performance.

Reducing surgical waiting times: Long waiting times are perceived as one of the major causes of the recent growth in private financing and care provision. Motivated by a desire to improve public confidence in the publicly financed health care system as well as quality of care, the MoH is planning a major initiative to reduce surgical waiting times. This will involve additional funding to expand hours of operation for surgical theaters as well as a series of organizational changes to improve efficiency.

Improving service levels in hospital EDs: As part of a broader effort to improve patient-centered care and service levels, the MoH is launching a major effort to reduce waiting times between patient arrival and the first contact with a health care professional. Strategies are to include enhanced physician, nurse, and physician assistant staffing, as well as engaging operations management experts to improve workflow.

Long-term care insurance: Israel's long-term care system is seriously fragmented, with service gaps, duplication of care, inefficient incentives, and inadequate investment in prevention and rehabilitation. The government is working on a plan to add institutional long-term care to the set of NHI benefits for which the health plans are responsible, with the plans also serving as the budget holders for institutional LTC.

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The Italian Health Care System, 2015

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What is the role of government?

The Italian National Health Service (*Servizio Sanitario Nazionale*) is regionally based and organized at the national, regional, and local levels. Under the Italian constitution, responsibility for health care is shared by the national government and the 19 regions and 2 autonomous provinces. The central government controls the distribution of tax revenue for publicly financed health care and defines a national statutory benefits package to be offered to all residents in every region—the "essential levels of care" (*livelli essenziali di assistenza*). The 19 regions and two autonomous provinces have responsibility for the organization and delivery of health services through local health units. Regions enjoy significant autonomy in determining the macro structure of their health systems. Local health units are managed by a general manager appointed by the governor of the region, and deliver primary care, hospital care, outpatient specialist care, public health care, and health care related to social care.

Who is covered and how is insurance financed?

Publicly financed health care: The National Health Service covers all citizens and legal foreign residents. Coverage is automatic and universal. Since 1998, undocumented immigrants have access to urgent and essential services. Temporary visitors can receive health services by paying for the costs of treatment.

Public financing accounted for 78 percent of total health spending in 2013, with total expenditure standing at 9.1 percent of GDP (OECD, 2014). The public system is financed primarily through a corporate tax (approximately 35.6% of the overall funding in 2012) pooled nationally and allocated back to regions, typically the source region (there are large interregional gaps in the corporate tax base, leading to financing inequalities), and a fixed proportion of national value-added tax revenue (approximately 47.3% of the total in 2012) collected by the central government and redistributed to regions unable to raise sufficient resources to provide the essential levels of care (Ministero dell'Economia e delle Finanze, 2012).

Regions are allowed to generate their own additional revenue, leading to further interregional financing differences. Every year the Standing Conference on Relations between the State, Regions, and Autonomous Provinces (with the presidents of the regions and representatives from central government as its members) sets the criteria (usually population size and age demographics) to allocate funding to regions. Local health units are funded mainly through capitated budgets.

The 2008 financial law established that regions would be financed through standard rates set on the basis of actual costs in the regions considered to be the most efficient. Established in legislation, this policy is not yet operating.

Since the National Health Service does not allow members to opt out of the system and seek only private care, substitutive insurance does not exist. At the same time, complementary and supplementary private health insurance is available (see below).

Privately financed health care: Private health insurance plays a limited role in the health system, accounting for roughly 1 percent of total spending in 2009. Approximately 15 percent of the population has some form of private insurance, which generally covers services excluded under the LEA, to offer a higher standard of comfort and privacy in hospital facilities, and wider choice among public and private providers. Some private health insurance policies also cover copayments for privately provided services, or a daily rate of compensation

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during hospitalization (Thomson et al., 2009). Tax benefits favor complementary over supplementary voluntary insurance.

There are two types of private health insurance: corporate, where companies cover employees and sometimes their families; and noncorporate, with individuals buying insurance for themselves or for their family. Policies, either collective or individual, are supplied by for-profit and nonprofit organizations. The market is characterized by the presence of three types of nonprofit organizations: voluntary mutual insurance organizations, and corporate and collective funds organized by employers/professional categories for their employees/members.

Approximately 74 percent of policies are purchased by individuals, while the remaining 26 percent are purchased by groups.

What is covered?

Services: Primary and inpatient care are free at the point of use. Positive and negative lists are defined using criteria related to medical necessity, effectiveness, human dignity, appropriateness, and efficiency in delivery. Positive lists identify services (e.g., pharmaceuticals, inpatient care, preventive medicine, outpatient specialist care, home care, primary care) offered to all residents. Outpatient optometrist visits are covered, while corrective lenses are not. Negative lists, on the other hand, identify services not offered to patients (e.g., cosmetic surgery), services covered only on a case-by-case basis (e.g., orthodontics and laser eye surgery) and services for which hospital admissions are likely to be inappropriate (e.g., cataract surgery). Regions can choose to offer services not included in the essential levels of care but must finance them themselves.

Essential levels of care do not include a specific list of mental health, preventive, public health, or long-term care services. Rather, national legislation defines an organizational framework for mental health services, with local health authorities obliged to define the diagnostic, curative, and rehabilitative services available. Essential levels of care also outline general community and individual levels of preventive services to be covered by the National Health Service, including hygiene and public health, immunization, and early diagnosis tools. They broadly state that rehabilitative and long-term inpatient care are to be delivered as part of a standard, inpatient curative care program.

Prescription drugs are divided into three tiers according to clinical effectiveness and, in part, cost-effectiveness. The first tier is covered in all cases; the second, only in hospitals; and the third tier is not covered. For some categories of drugs, therapeutic plans are mandated, and prescriptions must follow clinical guidelines.

Dental care is included in the essential levels of care for specific populations such as children (up to 16 years old), vulnerable people (the disabled, people with HIV, those with rare diseases), people in economic need, and individuals with urgent/emergency need. For others, dental care is generally not covered and is paid for out-of-pocket.

Cost-sharing and out-of-pocket spending: Procedures and specialist visits can be prescribed either by a general practitioner (GP) or by a specialist. While there are no user charges for GP consultations and hospital admission stays, patients pay a copayment for procedures and specialist visits up to a ceiling determined by law—currently, at €36.15 (USD48) per prescription.[1] Therefore, a patient who receives two separate prescriptions (e.g., an MRI scan and a laboratory test) after a visit pays €36.15 (USD48) for each prescription.

To address rising public debt, in July 2011 the government introduced, along with other economic initiatives, an additional €10 (USD13) copayment for each prescription. Copayments have also been applied to outpatient drugs at the regional level, and a €25 (USD33) copayment has been introduced for "inappropriate" use of emergency services (although some regions have not enforced this copayment). No other forms of deductibles

[1] Please note that, throughout this profile, all figures in USD were converted from EUR at a rate of about EUR0.76 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by OECD (2014b) for Italy.

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exist. Public and private providers under a contractual agreement with the National Health Service are not allowed to charge above the scheduled fees.

All individuals with out-of-pocket payments over €129 (USD170) in a given year are eligible for a tax credit equal to roughly one-fifth of their spending, but there are no caps.

In 2013, 18 percent of total health spending was paid out-of-pocket, mainly for drugs not covered by the public system and for dental care (OECD, 2014). Out-of-pocket payments can be used to access specialist care and, to a lesser extent, inpatient care delivered in private and public facilities to paying patients.

Safety net: Exemptions from cost-sharing are applied to people over age 65 and under age 6 who live in households with a gross income below a nationally defined threshold (approximately €36,000 [USD47,360]); people with severe disabilities, as well as prisoners, are exempt from any cost-sharing. People with chronic or rare diseases, people who are HIV-positive, and pregnant women are exempt from cost-sharing for treatment related to their condition. Most screening services are provided free of charge.

How is the delivery system organized and financed?

Primary care: Primary care is provided by self-employed and independent physicians, general practitioners (GP) and pediatricians, under contract and paid a capitation fee based on the number of people on their list (Lo Scalzo et al., 2009). Local health units also can pay additional allowances for the delivery of planned care to specific patients (e.g., home care for chronically ill patients), for reaching performance targets (e.g., to reward effective cost containment on pharmaceuticals, laboratory tests, and therapeutic treatments prescribed), or for delivering additional treatments (e.g., medications, flu vaccinations). Capitation is adjusted for age and accounts for approximately 70 percent of the overall payment. The variable portion comprises fee- for-service payment for specific treatments, including minor surgery, home care, preventive activities, and taking care of chronically ill patients.

Payment levels, duties, and responsibilities of GPs are determined in a collective agreement signed every three years by consultation between central government and the GPs' trade unions. In addition regions and local health units can sign contracts covering additional services.

In 2011, there were approximately 53,800 GPs and pediatricians (33.5%) and 106,800 hospital clinicians (66.5%) (Ministero della Salute, 2014). Patients are required to register with a gatekeeping GP, who has incentives to prescribe and refer only as appropriate: in most cases incentives are awarded only to those GPs and pediatricians who achieve a predetermined spending or consumption target (e.g., per capita spending on drugs or diagnostic imaging). People may choose any physician whose list has not reached the maximum number of patients allowed (1,500 for GPs and 800 for pediatricians) and may switch at any time.

In recent years the solo practice model has been progressively modified toward group practice, particularly in the northern part of the country. Legislation encourages GPs and pediatricians to work in three ways: base group practice, where GPs from different offices share clinical experiences, develop guidelines, and participate in workshops that assess performance; network group practice, which functions like base group practice but allows GPs/pediatricians to access the same patient electronic health record system; and advanced group practice, where GPs/pediatricians share the same office and patient health record system, and are able to provide care to patients beyond individual catchment areas. In 2010, approximately 67 percent of GPs and 60 percent of pediatricians were working in a team (Ministero della Salute, 2014). Group practices typically range from three to eight GPs.

General practitioners working in base group practices receive an additional €2.58 (USD3.4) per patient, while GPs in a network practice receive €4.7 (USD6.2) (the payment for pediatricians is €8 [USD11]). Lastly, GPs working in a group practice receive €7 (USD9) (€9 [USD12] for pediatricians). General practitioners or pediatricians employing a nurse or secretary receive an additional payment of €4 (USD5.3) for nurses and €3.5 (USD4.6) for a secretary.

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Some regions are promoting care coordination by asking their GPs to work in groups involving specialists, nurses, and social workers. The aim is for each group to be in charge of all the health needs of its assigned population. This is encouraged by additional payments to GPs (e.g., paying each GP €1.3 (USD1.7) per patient in Emilia-Romagna) and supplying teams with personnel, in most cases nurses and social workers.

Outpatient specialist care: Outpatient specialist care is generally provided by local health units or by public and private accredited hospitals under contract with them. Once referred, patients are given choice of any public or private accredited hospital, but are not allowed to choose a specific specialist. Outpatient specialist visits are generally provided by self-employed specialists working under contract with the National Health Service. They are paid an hourly fee contracted nationally between the government and the trade unions; the current rate is approximately €32 (USD42). Outpatient specialists can see private patients without any limitations, whereas specialists employed by local health units and public hospitals cannot. Multispecialty groups are more common in northern regions of the country.

Administrative mechanisms for paying primary care doctors and specialists: Patient copayment is limited to outpatient specialist visits and diagnostic testing, while primary care visits are provided free of charge. Copayments are usually paid by the patient before receiving the visit/test.

After-hours care: After-hours centers are generally located in local health unit–owned premises and staffed only by doctors employed on an hourly basis by the local health unit. The hourly rate, negotiated between the GP trade unions and government, is approximately equal to €25 (USD33). Following examination and initial treatment, the doctor can prescribe medications, issue employees' medical certificates, and recommend hospital admission. Guardia medica is a free telephone health service for emergency cases. It normally operates at night and on weekends, and the doctor on duty usually provides advice, in addition to home visits if needed.

Information on a patient's visit is not routinely sent to the patient's GP. To improve accessibility, government and GP associations are trying to promote a model where GPs, specialists, and nurses coordinate to ensure 24-hour access and avoid unnecessary use of hospital emergency departments. Implementation is uneven across regions.

Hospitals: Depending on the region, public funds are allocated by local health units to public and accredited private hospitals. In 2011 there were approximately 194,000 beds in public hospitals and 47,500 in private accredited hospitals (Ministero della Salute, 2014). Public hospitals either are managed directly by the local health units or operate as semi-independent public enterprises. A diagnosis-related group-based prospective payment system operates across the country and accounts for most hospital revenue but is generally not applied to hospitals run directly by local health units, where global budgets are common. Rates include all hospital costs, including those of physicians. Teaching hospitals receive additional payments (typically 8% to 10% of overall revenue) to cover extra costs related to teaching. There are considerable interregional variations in the prospective payment system, such as how the fees are set, which services are excluded, and what tools are employed to influence patterns of care. However, all regions have mechanisms for cutting fees once a spending threshold is reached, to contain costs and incentives to increase admissions.

In all regions, a portion of funding is administered outside the prospective payment system (e.g., funding of specific functions such as emergency departments and teaching programs).

Hospital-based physicians are salaried employees. Public hospital physicians are prohibited from treating patients in private hospitals; all public physicians who see private patients in public hospitals pay a portion of their extra income to the hospital.

Mental health care: Mental health care is provided by the National Health Service in a variety of community-based, publicly funded settings, including community mental health centers, community psychiatric diagnostic centers, general hospital inpatient wards, and residential and semiresidential facilities. In 2010 there were 1,737 residential facilities and 784 semiresidential facilities providing care to approximately 60,000 patients. Promotion and coordination of mental illness prevention, care, and rehabilitation are the responsibility of

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specific mental health departments in local health units. These are based on a multidisciplinary team, including psychiatrists, psychologists, nurses, social workers, educators, occupational therapists, people with training in psychosocial rehabilitation, and secretarial staff. In most cases primary care does not play a role in provision of mental health care; a few regions have experimented with assigning the responsibility of low-complexity cases (mild depression) to general practitioners (Lo Scalzo et al., 2009).

Long-term care and social supports: Patients are generally treated in residential (approximately 221,000 beds in 2011) or semiresidential (50,000 beds) facilities, or in community home care (approximately 606,000 cases). Residential and semiresidential services provide nurses, physicians, specialist care, rehabilitation services, medical therapies, and devices. Patients must be referred in order to receive residential care. Cost-sharing for residential services varies widely according to region, but is generally determined by patient income.

Community home care is funded publicly, whereas residential facilities are managed by a mixture of public and private, for-profit and nonprofit organizations. Community home care is not designed to provide physical or mental care services but to provide additional assistance during a treatment or therapy. In spite of government provision of residential and home care services, long-term care in Italy has traditionally been characterized by a low degree of public financing and provision as compared with other European countries.

Financial assistance for patients can take two forms:

- *Accompanying allowance*: Awarded by the National Pension Institute to all Italian citizens who need continuous assistance. The allowance, which is related to need but not to income or age, amounts to approximately €500 (USD658) per month.
- *Care voucher*: Awarded by municipalities on the basis of income, need, and clinical severity only to residents of those municipalities offering the service. The amount ranges between €300 and €600 (USD395 to USD789) per month.

Voluntary organizations still play a crucial role in the delivery of palliative care. A national policy on palliative care has been in place since the end of the 1990s and has contributed to an increase in services such as hospices, day care centers, and palliative care units within hospitals. In 2011 there were 158 hospices, with approximately 1,700 beds. But much still needs to be done to ensure the diffusion of palliative care services and disparities persist: northern regions cared, on average, for 51 patients per 100,000 residents, while in central and southern regions the rate fell to 25 patients.

What are the key entities for health system governance?

The Ministry of Health is currently structured into 12 directorates that oversee specific areas of health care (health care planning; essential levels of care and health system ethics; human resources and health professionals; information systems; pharmaceuticals and medical devices) or supervise the main institutions related to the Ministry of Health (e.g., National Health Council, National Institute of Health).

Key nongovernmental entities supporting the Ministry of Health include the National Health Council (which provides support for national health planning, hygiene and public health, pharmacology and pharmaco-epidemiology, continuing medical education for health care professionals, and information systems) and the National Institute of Public Health (which provides recommendations and control in the area of public health).

The National Committee for Medical Devices develops cost-benefit analyses and determines reference prices for medical devices. The Agency for Regional Health Services is the sole institution responsible for conducting comparative effectiveness analysis and is accountable to the regions and the Ministry of Health.

The National Pharmaceutical Agency is responsible for all matters related to the pharmaceutical industry, including prescription drug pricing and reimbursement policies. It is accountable to the Ministry of Health and the Ministry of Economy and Finance (Lo Scalzo et al., 2009).

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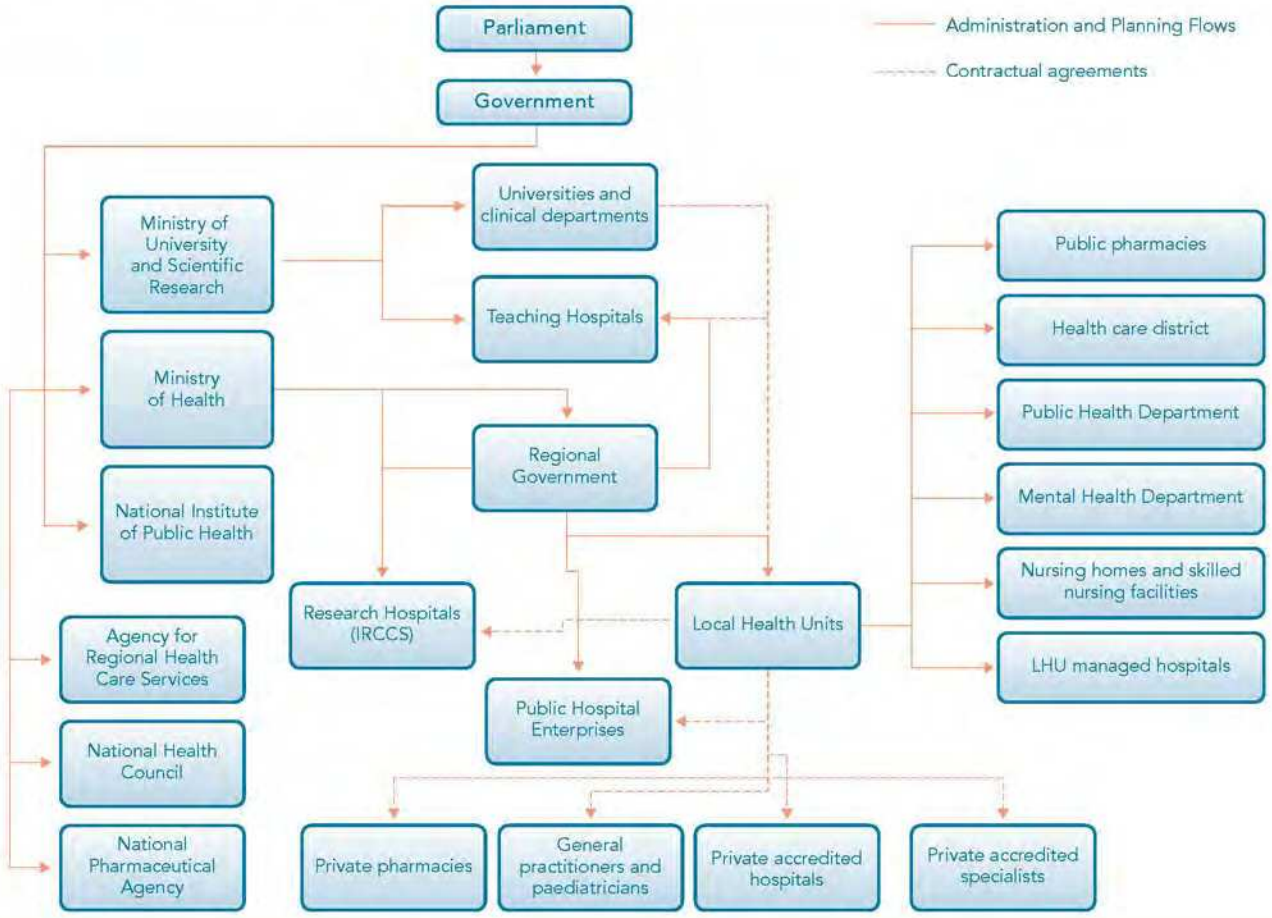
Organization of the Health System in Italy



Source: A. Donatini, Emilia-Romagna Regional Health Authority, 2014.

Payment rates for hospital and outpatient specialist care are determined by each region, with national rates (determined by the Ministry of Health) as a reference.

Some regional governments have established agencies to evaluate and monitor health care quality and to provide comparative effectiveness assessments and scientific support to regional health departments (see below). Regional governments periodically sign with the national government "Pacts for Health" linking additional resources to the achievement of health care planning and expenditure goals (see below).

Safeguarding of patients' rights has not been uniform and has depended on the level of effort of individual regions. Regions have implemented different models of empowerment: some through standing committees, which include members from citizens' associations, as an institutional means of patient involvement, while others have emphasized systematic patient satisfaction surveys.

Each public institution has an office for public relations (*Ufficio Relazioni con il Pubblico*) providing information to citizens and, in many cases, monitoring quality of services from the citizen's point of view.

What are the major strategies to ensure quality of care?

National and regional governments, responsible for upholding quality, ensure that services included in the essential levels of care are provided and waiting times are monitored. Several regions have introduced programs for prioritizing delivery of care on the basis of clinical appropriateness of services prescribed and patient severity

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(France et al., 2005). All doctors under contract with the National Health Service must be certified, and all National Health Service staff participate in compulsory continuing education. The National Commission for Accreditation and Quality of Care is responsible for outlining the criteria used to select providers and for evaluating regional accreditation models (including private hospitals), which vary considerably across the system. These models do not usually include periodic reaccreditation.

Legislation passed during the 1990s covers three main components of quality: input (quality of infrastructure and human resources); process (appropriateness and timeliness of interventions); and outcome (health status and patient satisfaction) (Lo Scalzo et al., 2009).

National legislation requires all public health care providers to issue a "health service chart" with information on service performance, quality indicators, waiting times, quality assurance strategies, and the process for patient complaints. These charts also have been adopted by the private sector for its accreditation process, and must be published annually, although dissemination methods are decided regionally. Most providers issue data through leaflets and the Internet, while nurses and other medical staff are offered financial performance incentives (linked to manager evaluations but not to publicly reported data).

The National Plan for Clinical Guidelines (*Piano Nazionale Linee Guida*) has been implemented in recent years and has produced guidelines on topics ranging from cardiology to cancer prevention and from appropriate use of antibiotics to cesarean delivery.

Some regions have introduced disease management programs, are experimenting with chronic care models (refer to the section on coordination) and maintain registries, mainly for cancer patients and diabetes. No national registries exist. Patient surveys are not used for quality control.

What is being done to reduce disparities?

Interregional inequity is a long-standing concern. The less affluent south trails the north in number of beds and availability of advanced medical equipment, has more private facilities, and less-developed community care services. Data show a rise in interregional mobility in the 1990s, with movement particularly from southern to central and northern regions (France, 1997) and an increasing gap between the north and south (Toth, 2014).

Income-related disparities in self-reported health status are significant, though similar to those in the Netherlands, Germany, and other European countries (Van Doorslaer and Koolman, 2004).

The National Health Plan for 2006–2008 cites overcoming large regional discrepancies in care quality as key objective for reform. Directing EU resources toward health services in eight regions in the south was a first step in 2007 in reducing this persistent variation. Regions receive a proportion of funding from an equalization fund (the National Solidarity Fund), which aims to reduce inequalities. Aggregate funding for the regions is set by the Ministry of the Economy and Finance, and the resource allocation mechanism is based on capitation adjusted for demographic characteristics and use of health services by age and sex.

What is being done to promote delivery system integration and care coordination?

Integration of health and social care services has recently improved, with a significant shift of long-term care from institutions to the communities, with an emphasis on home care. Community home care establishes a home care network that integrates the competencies of nurses, GPs, and specialist physicians with the needs and involvement of the family. General practitioners oversee the home care network, liaise with social workers and other sectors of care, and take responsibility for patient outcomes.

Regions have chronic patient management programs, dealing mainly with high-prevalence conditions such as diabetes, congestive heart failure, and respiratory conditions. All programs involve different competencies

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although the degree of evolution is varied across regions. Some regions are also trying to set up disease management programs based on the chronic care model.

The most recent Pact for Health, signed in July 2014, is a significant step toward care integration (see below): all regions must establish "primary care complex units" (*Unità Complesse di Cure Primarie*) involving GPs, specialists, nurses, and social workers.

Given that, traditionally, Italian GPs work in solo practice, shifting to this new organizational arrangement will require considerable effort. To further promote integration and adoption of multidisciplinary teams, medical homes are being encouraged in some regions. (Tuscany and Emilia-Romagna have invested considerable resources in activating and promoting medical homes. In Emilia-Romagna, for example, there are currently 62 medical homes providing multispecialty care to approximately 1 million people.)

What is the status of electronic health records?

The New Health Information System has been implemented incrementally since 2002 to establish a universal system of electronic records connecting every level of care. It provides information on the services, resource use, and costs, but does not cover all areas of health care; in particular, primary care is not covered, while hospital, emergency, outpatient specialist, residential and palliative care, and pharmaceuticals are. It currently contains administrative information on care delivered, as medical information appears more difficult to gather. No unique patient identifier exists at the national level.

A core component of the New Health Information System is the nationwide clinical coding program known as "bricks," one of the most mature elements of Italy's developing electronic health program. It aims at defining a common language to classify and codify concepts; at sharing methodologies for measuring quality, efficiency, and appropriateness of care; and at allowing an efficient exchange of information between the national level and regional authorities.

Some regions have developed computerized networks to facilitate communication between physicians, pediatricians, hospitals, and territorial services and to improve continuity of care. These networks allow automatic transfer of patient registers, services provided, prescriptions for specialist visits and diagnostics, and laboratory and radiology test outcomes. A few regions also have developed a personal electronic health record, accessible by patients, that contains all patient medical information, such as outpatient specialty care results, medical prescriptions, and hospital discharge instructions. Personal electronic health records should provide support to patients and clinicians across the whole process of care but diffusion is still limited.

There is also a slow movement from paper to electronic prescriptions. By the end of 2014, 80 percent of all prescriptions (drugs and specialist care) were to be issued electronically, but only five regions declared that they were able to reach the goal on time.

How are costs contained?

Containing health costs is a core concern of central government, as Italy's public debt is among the highest in industrialized nations. Fiscal capacity varies greatly across regions. To meet cost containment objectives, the central government can impose recovery plans on regions with health care expenditure deficits. These identify tools and measures needed to achieve economic balance: revision of hospital and diagnostic fees, reduction of the number of beds, increased copayments for pharmaceuticals, and reduction of human resources through limited turnover.

The Agency for Regional Health Services, in collaboration with the Ministry of Health, has authority to conduct health technology assessments and implement its findings at the regional level, but these are not yet formalized or undertaken systematically. Few regional health technology assessment agencies currently exist, and their primary function is to evaluate individual technologies. Assessments are not mandatory for new or referred

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procedures and devices. However, reference prices for medical devices and pharmaceuticals are set according to cost-effectiveness studies carried out by the National Committee for Medical Devices and the National Drugs Agency. Furthermore, the National Pharmaceutical Formulary bases coverage decisions in part on clinical effectiveness and cost-effectiveness. Prices for reimbursable drugs are set in negotiations between government and the manufacturer according to the following criteria: cost-effectiveness where no effective alternative therapies exist; comparison of prices of alternative therapies for the same condition; costs per day compared with those of products of the same effectiveness; financial impact on the health system; estimated market share of the new drug; and average prices and consumption data from other European countries. Prices for nonreimbursable drugs are set by the market.

What major innovations and reforms have been introduced?

Because of the regionalization of the health system, most innovations in the delivery of care take place at the regional rather than the national level, with some regions viewed as leaders in innovation. Significant innovations can be found in:

- *Pharmaceuticals*: Both the National Drugs Agency and the regions are particularly active in coordinating guidelines and rules to promote appropriate and cost-effective prescribing.
- *Hospital care*: Various innovations have been introduced concerning the overall organization, management of operations (e.g., planning of surgical theaters and delivery of drugs), and health information technology (e.g., electronic medical records, automation of administrative and clinical activities).

In August 2012 the parliament passed a law aimed at curbing and rationalizing public expenditure (the so-called spending review). The law promoted the prescription of generic drugs, cut the hospital bed ratio from 4 per 1,000 people to 3.7, and reduced public financing of the National Health Service by between €900M (USD1.2B) and €2.1B (USD2.8B) annually between 2012 and 2015. Many of the requirements of the law are still in the process of being implemented and effects have not yet been evaluated.

In 2012, the government approved a decree (named after Renato Balduzzi, who was health minister at that time) to reorganize health care at the regional level, with the introduction of teams of primary health care professionals to ensure 24-hour coverage; to update health care fees; to restructure governance of hospitals and local health units; to revise the list of reimbursable pharmaceuticals; and to introduce health technology assessment as a tool for renegotiating the price of less effective medicines. Evaluations of the impact of both laws are not yet available as their implementation is still under way.

The July 2014 Pact for Health defines funding (between €109B [USD143.4B] and €115B [USD151.3B] annually) for the years 2014 to 2016. In return, regions make explicit commitments to:

- Reduce hospitalizations through appropriate use of hospitals, with progress toward home care and the creation of community hospitals offering subacute care.
- Reorganize primary care: All regions will have to establish primary care complex units (*Unità Complesse di Cure Primarie*) (as described in the section on care integration) to replace all other forms of general practice networks (base group practice, network group practice, and advanced group practice).
- Revise hospital and specialist care fees in line with health inflation and with the underlying structure of health care costs.
- Revise copayments for outpatient specialist care to promote more equitable access. Copayments currently represent a barrier for disadvantaged sectors of the population.
- Strengthen the electronic records system.

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The Japanese Health Care System, 2015

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What is the role of government?

Government regulates nearly all aspects of the universal public health insurance system (PHIS). The national and local governments are required by law to ensure a system that efficiently provides good-quality and well-suited medical care to the nation. National government sets the fee schedule and gives subsidies to local governments, insurers, and providers. It also establishes and enforces detailed regulations for insurers and providers. Japan's 47 prefectures (regions) implement those regulations and develop regional health care delivery with funds allocated by the national government. More than 1,700 municipalities operate components of the PHIS and long-term care insurance and organize health promotion activities for their residents (Tatara and Okamoto, 2009).

Who is covered and how is insurance financed?

Publicly financed health insurance: The PHIS, comprising more than 3,400 insurers, provides universal primary coverage (National Institute of Population and Social Security Research, 2014). In 2013, estimated total health expenditure amounted to approximately 10 percent of GDP, 83 percent of which was publicly financed, mainly through the PHIS (OECD, 2015). Within the PHIS, premiums, tax-financed subsidies, and user charges accounted for about 49 percent, 38 percent, and 12 percent of the sum of health expenditures, respectively (MHLW, 2014b).

Citizens are mandated to enroll in one of the PHIS plans based on employment status and/or place of residence, as are resident noncitizens; undocumented immigrants and visitors are not covered. Insurance premiums and the basis upon which they are charged vary between types of insurance funds and municipalities. Government employees are covered by their own insurers (known as Mutual Aid Societies), as are some groups of professionals (e.g., doctors in private practice). Those who fail to keep up their enrollment must pay up to two years' worth of premiums when they reenter the system. Means-tested public assistance covers health care for its recipients. Citizens and resident noncitizens enrolled in the PHIS age 40 and over are mandatorily enrolled in long-term care insurance.

Private health insurance: Although the majority of the population holds some form of medical insurance, private insurance plays only a minor supplementary or complementary role. It developed historically as a supplement to life insurance and provides additional income in case of sickness, mainly in the form of lump-sum payments when insured persons are hospitalized or diagnosed with cancer or another specified chronic disease, or through payment of daily amounts during hospitalization over a defined period. Since the early 2000s, the number of standalone medical insurance policies has increased (Japan Institute of Life Insurance, 2013; Life Insurance Association of Japan, 2014).

Part of an individual's life insurance premium (up to JPY40,000, or USD380) can be deducted from taxable income. Small discounts can be applied to those employees whose employers have collective contracts with insurance companies. Both for-profit and nonprofit organizations operate private health insurance.

The provision of privately funded health care has been limited to services such as dental orthodontics, expensive artificial teeth, and treatment of traffic accident injuries (although treatment of these injuries is usually paid for by compulsory or voluntary automobile insurance.)

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What is covered?

Services: All PHIS plans provide the same benefits package, which is determined by the national government, usually following a decision by the Central Social Insurance Medical Council, a governmental body. The package covers hospital, primary, and specialist ambulatory and mental health care, approved prescription drugs, home care services by medical institutions, hospice care, physiotherapy, and most dental care. It does not cover corrective lenses unless recommended by physicians for children under age 9, or optometry services provided by nonphysicians. Home care services by nonmedical institutions are covered by long-term care insurance. Preventive measures, including screening, health education, and counseling, are covered by health insurance plans, while cancer screenings are delivered by municipalities.

Cost-sharing and out-of-pocket spending: All enrollees have to pay a 30 percent coinsurance rate for services and goods received, except for children under age 3 (20%), adults between 70 and 74 with lower incomes (20%), and those 75 and over with lower incomes (10%). There are no deductibles. Annual expenditures on health services and goods, including copayments and payments for balance billing and over-the-counter drugs, between JPY100,000 (USD 950) and JPY2 million (USD19,000) can be deducted from taxable income.[1] In 2012, out-of-pocket payments for cost-sharing accounted for 14 percent of total health expenditures (OECD, 2015). Some employer-based health insurance plans offer reduced cost-sharing. Providers are prohibited from charging extra fees except for some services specified by the Ministry of Health, Labor and Welfare, including amenity beds, experimental treatments, the outpatient services of large multispecialty hospitals, after-hours services, and hospitalizations of 180 days or more.

Safety net: Catastrophic coverage stipulates a monthly out-of-pocket threshold, which varies according to enrollee age and income—for example, JPY80,100 (USD761) for people under age 70 with an average income; above this threshold, 1 percent coinsurance applies. There is a ceiling for low-income people, who do not pay more than JPY35,400 (USD336) a month. Subsidies (mostly restricted to low-income households) reduce the burden of cost-sharing for people with disabilities, mental illness, and specified chronic conditions. There is an annual household health and long-term care out-of-pocket payments ceiling, which varies between JPY340,000 (USD3,230) and JPY1.26 million (USD11,970) per enrollee according to income and age, above which such payments can be reimbursed. Enrollees with employer-based insurance who are on parental leave are exempt from payment of premiums. Enrollees in Citizens Health Insurance (for the unemployed, self-employed, and retired, and those others under 75) with low income and those with moderate income who face sharp, unexpected income reductions are eligible for reduced premium payments. Reduced coinsurance rates apply to patients with 306 designated long-term diseases, varying by income, when using designated health care providers.

How is the delivery system organized and financed?

Primary care: Primary care is provided at most clinics and some hospital outpatient departments. Primary care and specialist care are not regarded as distinct disciplines, although it has been argued that they should be. Approximately one-third of physicians are salaried employees of clinics, and virtually all others are self-employed. Clinics are often owned by physicians or by medical corporations (special legal entities for health care management, usually controlled by physicians, that own hospitals as well as clinics), but sometimes by local governments or public agencies.

Primary care practices typically include teams with a physician and a few employed nurses. In 2011, the average clinic had 7.2 full-time-equivalent workers, including 1.2 physicians, 1.8 nurses, and 2.1 clerks.[2] Clinics can dispense medication (which doctors can provide directly to patients). Use of pharmacists, however, has been growing; 67 percent of prescriptions were filled at pharmacies in 2013 (Japan Pharmaceutical Association, 2014). Patients are not required to register with a practice, and there is no strict gatekeeping, although government encourages patients to choose their family doctors, and there are patient disincentives for

[1] Please note that, throughout this profile, all figures in USD were converted from JPY at a rate of about JPY105 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015b) for Japan.

[2] The figures are calculated from statistics of the Ministry of Health, Labor and Welfare (2012a).

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self-referral including extra charges for initial consultations at some large hospitals with many specialties. Patients can choose and drop in at any clinic, except those requiring reservations. An entity managing many clinics can share their resources, but there is no cross-entity resource sharing.

Payments for primary care are based principally on a complex national fee-for-service schedule, which includes financial incentives for coordinating the care of patients with chronic diseases, and for team ambulatory and home care. The schedule, set by the government (explained below), includes both primary and specialist services, which have common prices for defined services such as consultations, examinations, laboratory tests, imaging tests, and defined chronic disease management. Per-case payments can be chosen by providers in select cases, such as daily payments for pediatrics care and monthly payments for treating patients with diabetes. Bundled payments are not used. Balance billing is prohibited, but providers can charge for designated services.

Outpatient specialist care: Most outpatient specialist care is provided in hospital outpatient departments, but some is also available at clinics, where patients can visit without referral. Fees are determined by the same schedule that applies to primary care, as they do not usually vary by provider type, although some services must be provided by specialists in order to be covered by the PHIS. There are no collective regulations on payments for specialists. At hospitals, specialists are usually salaried, with additional payments such as night duty allowance. Those working at public hospitals can work at other health care institutions and privately with the approval of their hospitals, but in such cases they usually provide services covered by the public system. The employment status of specialists at clinics varies similarly to that of primary care physicians.

Administrative mechanisms for paying primary care doctors and specialists: There are no direct payments to primary care doctors and specialists in the PHIS. Although in principle patients are liable for copayments at point of service, practically all fee transactions are mediated by statutory bodies. Self-employed clinic-based primary care physicians and specialists receive all payments for services through the fee schedule, pay for employees and other inputs, allocate funds for investments, and retain surpluses. Legal entities managing clinics and hospitals send insurance claims, mostly online, to insurers in the PHIS.

After-hours care: After-hours care is provided by hospital outpatient departments, where on-call physicians are available, and by some regular clinics and after-hours care clinics owned by local governments and staffed by physicians and nurses that local medical societies provide. Hospitals and clinics are paid "top-up" fees for after-hours care, including fees for telephone consultations. There is no strict formal requirement for clinics to provide such services, although physicians have a general obligation to consult with patients when requested. Patients can walk in at hospitals and clinics. National government grants subsidies to local governments for these clinics. Patient information from after-hours clinics is provided to family physicians if necessary (necessary information is often handed to patients to show to family physicians). There is a national pediatric medical advice telephone line available after hours.

Hospitals: As of 2013, 14 percent of hospitals are owned by national or local governments or closely related agencies (MHLW, 2014c); most of the rest are private and not-for-profit, some of which receive subsidies because they are designated as having partly public roles. More than 20 percent of beds are in public hospitals; the rest are in not-for-profit hospitals. The entry of private for-profit companies in the hospital sector is now prohibited, while existing hospitals established by for-profit companies for their employees (e.g., Toyota) are allowed to continue. Payments to hospitals from the PHIS include costs for physicians' salaries.

Consultation fees for large hospitals and academic medical centers are lower than those for small hospitals and clinics. More than half of all acute-care hospital beds are paid for by the Diagnosis Procedure Combination (DPC) modification, a case-mix classification similar to diagnosis-related groups (DRGs) (Matsuda, et. al., 2008), and the rest are paid for solely on a fee-for-service basis. Hospitals choose whether to receive the DPC payments or to remain under fee-for-service. The DPC payment consists of a fee-for-service and a DPC component in the form of a per diem payment determined by the DPC grouping, which includes basic hospital services and less expensive treatments; the fee-for-service component includes surgical procedures, rehabilitative services, and other specified expensive services (OECD, 2009). DPC rates are multiplied by a hospital-specific coefficient that keeps them relatively in line with fee-for-service payments; it may also limit

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incentives for providers to contain cost, although the correlation has not yet been formally evaluated. Episode-based payments are not used.

Mental health care: Mental health care is provided in outpatient, inpatient, and home care settings, with patients charged the standard 30 percent coinsurance (although there is reduced cost-sharing and other financial protections for patients in the community). Covered services include psychological tests and therapies, pharmaceuticals, and rehabilitative activities. Specialized mental clinics and hospitals exist, but services for depression, dementia, and other common conditions are integrated with primary care. Most psychiatric beds are in private hospitals owned by medical corporations (MHLW, 2014c).

Long-term care and social supports: National compulsory long-term care insurance (LTCI), administered by the municipalities, covers those age 65 and older and some disabled people ages 40 to 64. It covers home care, respite care, domiciliary care, disability equipment, assistive devices, and home modification. Medical services are covered by the PHIS, as are palliative care and hospice care in hospitals and medical services provided in home palliative care, while nursing services are covered by LTCI. Long-term home care services can be considered a part of home hospice services as dying patients become eligible.

Roughly half of long-term care financing comes through taxation and half through premiums. Citizens age 40 and over pay income-related premiums along with PHIS premiums. Employers pay the same premium as that of their employees. Premiums for those age 65 and older, also income-based (including pensions), and set by municipalities based on estimated expenditures, are paid only by the beneficiaries. A 10 percent coinsurance rate applies to all covered services, up to an income-related ceiling. There is additional copayment for bed and board in institutional care, but it is waived or reduced for those with low income (all costs for those with means-tested social assistance are paid from local and national tax revenue).

Eligible people are entitled to use long-term services up to needs-based ceilings (called "care levels") set by local LTCI boards, according to assessment of physical and mental conditions. People are not allowed to buy unlisted services or services from non-LTCI providers with the budget provided, but they can purchase such services with their own money. Care management—covered by LTCI and offered by public, not-for-profit, and for-profit providers—is available to help people arrange long-term care services.

The majority of home care providers are private; 64 percent were for-profit, 35 percent not-for-profit, and 0.4 percent public in 2013 (MHLW, 2014a). While for-profits are not allowed to provide institutional care under LTCI, there are private nursing homes for which residents pay full costs (MHLW, 2013).

Family care leave benefits (part of employment insurance) are paid for up to three months when employees take leave to care for their families. Additionally, more than half of the municipalities have established marginal financial supports, mostly limited to those with lower incomes, with their own financial capacities and legislations (Kwon, 2014).

What are the key entities for health system governance?

The Social Security Council, a statutory body within the Ministry of Health, Labor and Welfare, is in charge of developing national strategies on quality, safety, and cost control, and sets guidelines for determining provider fees. Within the Ministry, the Central Social Insurance Medical Council defines the benefit package and fee schedule. National government and prefectures devise cost-control plans (described below).

The Japan Council for Quality Health Care, a nonprofit organization, works to improve quality throughout the health system and develops clinical guidelines, although it does not have any regulatory power to penalize poorly performing providers. Specialist societies themselves also produce clinical guidelines.

Technology assessment of pharmaceuticals and medical devices is conducted by the Pharmaceutical and Medical Devices Agency, a governmental regulatory agency. It also sets the Public Health Insurance Drug Price List, which is a list of pharmaceuticals and their prices covered by the PHIS (English Regulatory Information Task

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Force: Japan Pharmaceutical Manufacturers Association 2012). The criteria for coverage include clinical effectiveness but not economic appraisal. Since 2012, the agency has been discussing the possible application of comparative cost-effectiveness studies in its decision-making (described below).

Nonprofit organizations work toward public engagement and patient advocacy, and every prefecture establishes a health care council to discuss the local health care plan. Under the Medical Care Law, these councils must have members representing patients.

The Japan Fair Trade Commission, an independent governmental administrative commission, promotes fair competition in health care as well as other sectors.



What are the major strategies to ensure quality of care?

By law, prefectures are responsible for making health care delivery "visions," which include detailed plans on cancer, stroke, acute myocardial infarction, diabetes mellitus, psychiatric disease, pediatric, and home care, as well as emergency, prenatal, rural, and disaster medicine. These plans include structural, process, and outcome indicators, as well as strategies for effective and high-quality delivery. Prefectures promote collaboration between providers to achieve them, with or without subsidies as financial incentives.

Waiting times are generally not monitored by government, although there is cause for concern in some clinical areas, such as palliative care. Although there are structural health care delivery regulations, relatively few apply to process and outcomes.

Prefectures are in charge of the annual inspection of hospitals. Sanctions include reduced reimbursement rates if staffing per bed falls below a certain ratio. Hospital accreditation, on the other hand, is voluntary and undertaken largely as an improvement exercise; roughly one-third of hospitals are accredited by the Japan Council for Quality Health Care. However, there is no disclosure of names of hospitals that fail the accreditation process. The Ministry of Health, Labor and Welfare organizes and financially supports a voluntary benchmarking project, in which hospitals report quality indicators on their websites.

In order to practice, physicians are required to obtain a license by passing a national exam, but they are not subject to revalidation. However, specialist societies have introduced revalidation for qualified specialists. Clinical audits are voluntary. Public reporting on performance has been discussed but is not yet implemented.

Every prefecture has a medical safety support center for handling complaints and promoting safety. Since 2004, advanced academic and public hospitals have been required to report adverse events to the Japan Council for Quality Health Care.

Disease and medical device registries have been developed on a voluntary basis, possibly to be used for quality improvement in the future. Surveys of hospital patients' experiences are conducted every three years.



What is being done to reduce disparities?

Reducing health disparities between population groups has been a general goal since 2012. The two explicit targets are a reduction of disparities in healthy life expectancies between prefectures and an increase in the number of local government entities that make efforts to solve health disparity issues (MHLW, 2012b). There is another plan to reduce disparities among prefectures in cancer treatment delivery, with each prefecture setting treatment targets. Health variations between regions are regularly reported by government. Health variations between socioeconomic groups and variations in health care access are occasionally measured and reported by researchers, some of them funded by the Ministry of Health, Labor and Welfare.

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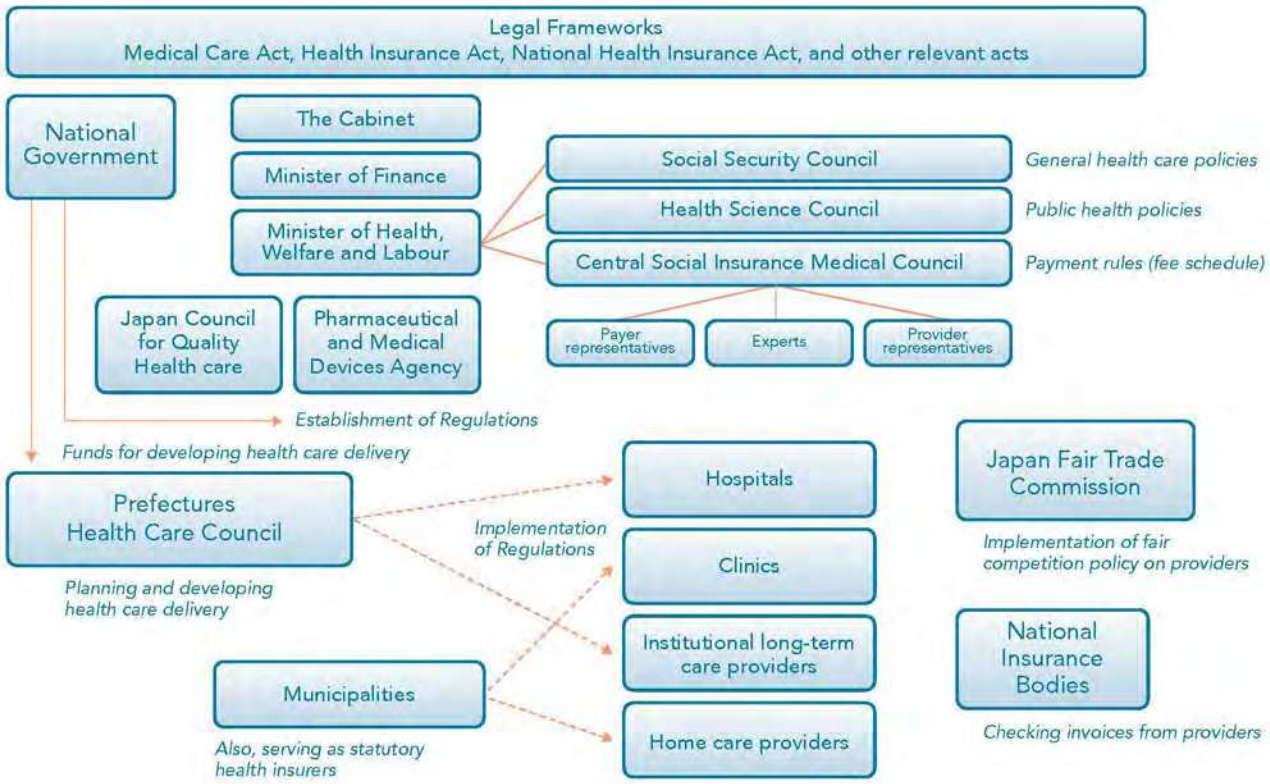
Organization of the Health System in Japan



Notes: This chart illustrates a very simplified structure of the complex health care governance in Japan.

Source: R. Matsuda, College of Social Sciences, Ritsumeikan University, 2015.

What is being done to promote delivery system integration and care coordination?

The national government prioritizes the general coordination of care, including coordination in mental health care, and has introduced financial incentives for hospitals and clinics, particularly in cancer, stroke, cardiac, and palliative care. Hospitals admitting stroke victims or patients with hip fractures can receive additional fees if they use post-discharge protocols and have contracts with clinic physicians to provide effective follow-up after discharge, for which those physicians also receive additional fees. The government also provides subsidies to leading providers in the community to facilitate care coordination.

There are more than 4,000 "community comprehensive support centers" to coordinate services, particularly for those with long-term conditions. Funded by LTCI, they employ care managers, social workers, and long-term care support specialists. No pooled funding of the PHIS and LTCI exists.

Regional and large-city governments are required to establish councils to promote integration of care and support for patients with 306 designated long-term diseases.

What is the status of electronic health records?

Electronic health record networks have been developed only as experiments in selected areas. Interoperability between providers has not been generally established. Currently, experiments are under way to make personal health information available to patients and providers via cloud computing. The Social Security and Tax Number

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System (SSTNS), a system of unique identifiers, will begin in 2016. It will be used for social security from its inception, and for health services, possibly including medical records, starting in 2018.

How are costs contained?

Price regulation for all services under the PHIS is a critical cost-containment mechanism (Ikegami and Anderson, 2012). The fee schedule is revised every two years by the government, following informal stakeholder negotiations, and is based on the estimated overall rate of change in public health care expenditures and expenditures in different health care sectors.

For medical, dental, and pharmacy services, the Central Social Insurance Medical Council revises fees on an item-by-item basis in order to meet overall spending targets set by the cabinet. Highly profitable categories see larger reductions. The revisions of prices of pharmaceuticals and devices are determined based on a market survey of actual current prices (which are often less than the listed prices). Drug prices can be revised downward for new drugs selling in greater volume than expected and for brand-name drugs when generic equivalents hit the market. Prices of medical devices in other countries are also considered in the revision.

Negotiations between stakeholders take place only for the purpose of revising the fee schedule and the rule for deciding pharmaceutical prices. Whether cost-sharing and the existing competition between providers contain costs is unclear.

The number of hospital beds is regulated by prefectures in accordance with national guidelines. The national medical student capacity, which is increasing since 2007 owing to physician shortages, is also regulated by the government.

The government's Cost-Containment Plan for Health Care is intended to promote healthy behavior, shorten hospital stays through care coordination and home care development, and increase generic substitution. Each prefecture makes cost-control plans in accordance with the plan. Both financial incentives in the fee schedule and other incentives, including education and training, are used. Peer review committees in each prefecture also monitor claims and may deny payment for services deemed inappropriate.

Currently, some pharmaceuticals whose medical effectiveness is considered uncertain are not covered by the PHIS. A trial cost-effectiveness evaluation for coverage of selected pharmaceuticals and medical devices is scheduled for fiscal year 2016.

What major innovations and reforms have been introduced?

Community-based health insurance plans in the PHIS, operated by municipalities, usually insure residents who are sicker and less well-off than those covered by employment-based insurance plans. The plans vary significantly in the number they insure, from fewer than 100 to more than half a million. To mitigate financial risk in small plans, the national government has gradually expanded cross-subsidies between community-based plans while keeping its and local governments' subsidies. With increasing financial pressures and the development of region-based governance, plans are being restructured under the 2015 Health Care Reform Act: from 2018, regions will take overall administrative responsibility for community-based plans and work together with municipalities, which will still be insurers of their residents, to set premium rates and to collect premiums. Meanwhile, subsidies from the national government to the regions are to be slightly increased to help plans, and those with low incomes, with excessive financial burdens.

A plan to strengthen the financial incentive for patients to use family physicians is intended to decrease demand on hospital outpatient departments. Although hospitals with 200 beds or more are currently allowed to charge additional fees to patients who have no referral for outpatient consultations, fewer than half of such hospitals have opted for this extra charge. Under the Health Care Reform Act of 2015, highly specialized large-scale hospitals with 500 beds or more will have an obligation to promote care coordination between providers in the community, as well as to charge additional fees to such patients.

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The Dutch Health Care System, 2015

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What is the role of government?

In the Netherlands, the national government has overall responsibility for setting health care priorities, introducing legislative changes when necessary, and monitoring access, quality, and costs. It also partly finances social health insurance for the basic benefit package (through subsidies from general taxation and reallocation of payroll levies among insurers through a risk adjustment system) and the compulsory social health insurance system for long-term care. Prevention and social support are not part of social health insurance but are financed through general taxation. The 2015 national reforms to long-term care made municipalities and health insurers responsible for most outpatient long-term services and all youth care under a provision-based approach (with a great level of freedom at the local level).

Who is covered and how is insurance financed?

Publicly financed health insurance: In 2013, the Netherlands spent 12 percent of GDP on health care, and 78 percent of curative health care services were publicly financed. All residents (and nonresidents who pay Dutch income tax) are mandated to purchase statutory health insurance from private insurers. People who conscientiously object to insurance, as well as active members of the armed forces (who are covered by the Ministry of Defense), are exempt. Insurers are required to accept all applicants, and enrollees have the right to change their insurer each year.

Apart from acute care, long-term care, and obstetric care, undocumented immigrants have to pay for most health care themselves (they cannot take out health insurance). However, some mechanisms are in place to reimburse costs that undocumented immigrants are unable to pay. For asylum seekers, a separate set of policies has been developed. Permanent residents (for more than 3 months) are obliged to purchase private insurance coverage. Visitors are required to purchase insurance for the duration of their visit if they are not covered through their home country.

Statutory health insurance is financed under the Health Insurance Act, through a nationally defined, income-related contribution, a government grant for the insured below age 18, and community-rated premiums set by each insurer (everyone with the same insurer pays the same premium, regardless of age or health status). Contributions are collected centrally and issued among insurers in accordance with a risk-adjusted capitation formula that considers age, gender, labor force status, region, and health risk (based mostly on past drug and hospital utilization).

Insurers are expected to engage in strategic purchasing, and contracted providers are expected to compete on both quality and cost. The insurance market is dominated by the four largest insurer conglomerates, which account for 90 percent of all enrollees. Currently, there is a ban on the distribution of profits to shareholders.

Private (voluntary) health insurance: In addition to statutory coverage, most of the population (84%) purchases a mixture of complementary voluntary insurance covering benefits such as dental care, alternative medicine, physiotherapy, spectacles and lenses, contraceptives, and the full cost of copayments for medicines (excess costs above the limit for equivalent drugs—an incentive for using generics). Premiums for voluntary insurance are not regulated; insurers are allowed to screen applicants based on risk factors and offer both statutory and voluntary benefits. Nearly all of the insured purchase their voluntary benefits from the same (mostly nonprofit) insurer that provides their statutory health insurance. People with voluntary coverage do not

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receive faster access to any type of care, nor do they have increased choice of specialist or hospital. In 2013, voluntary insurance accounted for 7.6 percent of total health spending.

What is covered?

Services: In defining the statutory benefits package, government relies on advice from the National Health Care Institute. Health insurers are legally required to provide a standard benefits package including, among other things, care provided by general practitioners (GPs), hospitals, and specialists; dental care through age 18 (coverage after that age is confined to specialist dental care and dentures); prescription drugs; physiotherapy through age 18; basic ambulatory mental health care for mild-to-moderate mental disorders, including a maximum of five sessions with a primary care psychologist; and specialized outpatient and inpatient mental care for complicated and severe mental disorders. In case the duration exceeds three years, the last of these is financed under the Long-term Care Act (see below).

Some treatments, such as general physiotherapy and pelvic physiotherapy for urinary incontinence, are only partially covered for some people with specific chronic conditions, as are the first three attempts at in vitro fertilization. Some elective procedures, such as cosmetic plastic surgery without a medical indication, dental care above age 18, and optometry, are excluded. A limited number of effective health improvement programs (e.g., smoking cessation) are covered, and weight management advice is limited to three hours per year.

As of 2015, home care is a shared responsibility of the national government, municipalities (day care, household services), and insurers (nursing care at home), and is financed through the Health Insurance Act. Hospice care is financed through the Long-term Care Act. Prevention is not covered by social health insurance, but falls under the responsibility of municipalities.

Cost-sharing and out-of-pocket spending: As of 2015, every insured person over age 18 must pay an annual deductible of EUR375 (USD455) for health care costs, including costs of hospital admission and prescription drugs but excluding some services, such as GP visits.[1] Apart from the overall deductible, patients are required to share some of the costs of selected services, such as medical transportation or medical devices, via copayments, coinsurance, or direct payments for goods or services that are reimbursed up to a limit, such as drugs in equivalent-drug groups. Providers are not allowed to balance-bill above the fee schedule. Patients with an in-kind insurance policy may be required to share costs of care from a provider that is not contracted by the insurance company. Out-of-pocket expenses represented 13.8 percent (45% through deductible) of health care spending in 2013 (author's calculation).

Safety net: GP care and children's health care are exempt from cost-sharing. Government also pays for children's coverage up to the age of 18 and provides subsidies (health care allowances), subject to asset testing and income ceilings, to cover community-rated premiums for low-income families (singles with annual income of less than EUR26,316 [USD31,896] and households with income less than EUR32,655 [USD39,580]). Approximately 5.4 million people receive allowances set on a sliding scale, ranging from EUR5.00 (USD6.10) to EUR78.00 (USD95.00) per month for singles and from EUR9.00 (USD11.00) to EUR 149.00 (USD181.00) for households, depending on income.

How is the delivery system organized and financed?

Primary care: There were more than 11,300 practicing primary care doctors (GPs) in 2014 and more than 20,400 specialists in 2013. Nearly 33 percent of practicing GPs worked in group practices of three to seven, 39 percent worked in two-person practices, and just over 28 percent worked solo. Most GPs work independently or in a self-employed partnership; only 11 percent are employed in a practice owned by another GP.

[1] Please note that, throughout this profile, all figures in USD were converted from EUR at a rate of about EUR0.83 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for the Netherlands.

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The GP is the central figure in Dutch primary care. Although registration with a GP is not formally required, most citizens are registered with one they have chosen, and patients can switch GPs without formal restriction. Referrals from a GP are required for hospital and specialist care.

Many GPs employ nurses and primary care psychologists on salary. Reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a doctor accrue to the GP. Care groups are legal entities (mostly GP networks) that assume clinical and financial responsibility for the chronic disease patients who are enrolled; the groups purchase services from multiple providers. To incentivize care coordination, bundled payments are provided for certain chronic diseases—diabetes, cardiovascular conditions, and chronic obstructive pulmonary disease (COPD)—and efforts are under way to implement them for chronic heart failure and depression.

In 2015, the government introduced a new GP funding model comprising three segments. Segment 1 (representing 75% of spending) funds core primary care services and consists of a capitation fee per registered patient, a consultation fee for GPs (including phone consultation), and consultation fees for ambulatory mental health care at the GP practice. The Dutch Health Care Authority (*Nederlandse Zorgautoriteit*) determines national provider fees for this segment. Segment 2 (15% of spending) consists of funding for programmatic multidisciplinary care for diabetes, asthma, and COPD, as well as for cardiovascular risk management; prices are negotiated with insurers. Segment 3 (10% of spending) provides GPs and insurers with the opportunity to negotiate additional contracts—including prices and volumes—for pay-for-performance and innovation. Self-employed GPs earned average gross annual income of €97,500 (USD117,000) in 2012, while salaried GPs earned €80,000 (USD96,000).

Outpatient specialist care: Nearly all specialists are hospital-based and either in group practice (in 2012, 54% of full-time-equivalent specialists, paid under fee-for-service) or on salary (46%, mostly in university clinics). As of 2015, specialist fees are freely negotiable as a part of hospital payment. This so-called "integral funding" dramatically changed the relationship between medical specialists and hospitals. Hospitals now have the responsibility of allocating their financial resources among their specialists.

There is a nascent trend toward working outside of hospitals—for example, in growing numbers of (mostly multidisciplinary) ambulatory centers—but this shift is marginal, and most ambulatory centers remain tied to hospitals. Specialists in ambulatory centers tend to work most of the time in academic or general hospitals. Only a small minority of doctors working in hospitals choose to work in ambulatory centers for part of their time. Ambulatory care center specialists are paid fee-for-service, and the fee schedule is negotiated with insurers. Medical specialists are not allowed to charge above the fee schedule. Patients are free to choose their provider (following referral), but insurers may set different conditions (e.g., cost-sharing) for different choices within their policies (Schäfer et al., 2010).

Administrative mechanisms for paying primary care doctors and specialists: The annual deductible (see above) is paid to the insurer. The insured have the option of paying the deductible before or after receiving health care and may choose to pay all at once or in installments. Other copayments—those for drugs or transportation, for example—have to be paid directly to the provider.

After-hours care: After-hours care is organized at the municipal level in GP "posts," which are centers, typically run by a nearby hospital, that provide primary care between 5 p.m. and 8 a.m. Specially trained assistants answer the phone and perform triage; GPs decide whether patients need to be referred to hospital. The GP post sends the information regarding a patient's visit to his or her regular GP. There is no national medical telephone hotline.

Hospitals: In July 2014, there were 131 hospitals and 112 outpatient specialty clinics spread among 85 organizations, including eight university medical centers. Practically all organizations were private and nonprofit. In 2013, there were also more than 260 independent private and nonprofit treatment centers whose services were limited to same-day admissions for nonacute, elective care (e.g., eye clinics, orthopedic surgery centers) covered by statutory insurance.

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Hospital payment rates (including doctor fees) are determined through negotiations between each insurer and each hospital over price, quality, and volume. The great majority of payments take place through the case-based diagnosis treatment combination system, and the rates for approximately 70 percent of hospital services are freely negotiable; the remaining 30 percent are set nationally. The number of diagnosis treatment combinations was reduced from 30,000 to 4,400 in 2012. Diagnosis treatment combinations cover both outpatient and inpatient as well as specialist costs, strengthening the integration of specialist care within the hospital organization.

Mental health care: Mental health care is provided in basic ambulatory care settings, such as GP offices, for mild to moderate mental disorders. In cases of complicated and severe mental disorders, GPs will often refer patients to a psychologist, an independent psychotherapist, or a specialized mental health care institution. The delivery of preventive mental health care is the responsibility of municipalities and is governed by the Social Support Act.

A policy of further integration of general practice and mental health was agreed on in 2012, with the goals of ensuring that patients receive timely care from the right source and reducing the need for specialized care. For several years, policymakers have been aiming to substitute outpatient care for inpatient care, reflected in the steady increase in the number of GPs that employ primary care psychologists.

Long-term care and social supports: A substantial proportion of long-term care is financed through the Long-term Care Act (*Wet langdurige zorg*), a statutory social insurance scheme for long-term care and uninsurable medical risks and cost that cannot be reasonably borne by individuals. It operates nationally, and taxpayers pay a contribution based on taxable income. The remainder of services are financed through the Social Support Act, from general sources. Long-term care encompasses residential care; personal care, supervision, and nursing; medical aids; medical treatment; and transport services. Cost-sharing depends on size of household, annual income, indication, assets, age, and duration of care. In 2014, copayments covered 7 percent of total spending in the compulsory long-term care (LTC) scheme.

With funding provided through a block grant from the national government, municipalities are responsible for household services, medical aids, home modifications, services for informal caregivers, preventive mental health care, transport facilities, and other assistance, in accordance with the Social Support Act (*Wet Maatschappelijke Ondersteuning*). Municipalities have a great deal of freedom in how they organize services, including needs assessments, and in how they support caregivers (e.g., through the provision of respite care or a small allowance).

Lont-term care is mostly provided by private, nonprofit organizations, including home care organizations, residential homes, and nursing homes. Most palliative care is integrated into the health system and delivered by general practitioners, home care providers, nursing homes, specialists, and volunteer workers.

Under both the Social Support Act and the Long-term Care Act, personal budgets are provided for patients to buy and organize their own long-term care, and under the Long-term Care Act are set at 66 percent of rates paid for in-kind services.

What are the key entities for health system governance?

Since 2006, the Ministry of Health's role has been to safeguard health care from a distance rather than managing it directly. It is responsible for the preconditions pertaining to access, quality, and cost of the health system, has overall responsibility for setting priorities, and may, when necessary, introduce legislation to set strategic priorities.

A number of arm's-length agencies are responsible for setting operational priorities. At the national level, the Health Council advises government on evidence-based medicine, health care, public health, and environmental protection. The National Health Care Institute advises government on the components of the statutory benefits package and has various tasks relating to quality of care, professions and training, and the insurance system (e.g., risk adjustment). The Medicines Evaluation Board oversees the efficacy, safety, and quality of medicines.

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Decisions about the benefits package rest with the health minister. The Dutch Health Care Authority (*Nederlandse Zorgautoriteit*) has primary responsibility for ensuring that the health insurance, health care purchasing, and care delivery markets all function appropriately (e.g., by setting the prices for 30 percent of diagnosis treatment combinations). Meanwhile, the Dutch Competition Authority (*Autoriteit Consument en Markt*) enforces antitrust laws among both insurers and providers. The Health Care Inspectorate (IGZ) supervises quality, safety, and accessibility of care. Self-regulation by medical doctors is also an important aspect of the Dutch system (Smith et al., 2012). Private insurers are tasked with increasing health system efficiency and cost control through prudent purchasing of health services.

The patient movement consists of a wide range of organizations, some for specific diseases and some functioning as umbrella organizations. The patient umbrella organization *Nederlandse Patiënten Consumenten Federatie* conducts a range of activities to promote transparency. Health Information Technology is not centralized in one body. The Union of Providers for Health Care Communication (*De Vereniging van Zorgaanbieders voor Zorgcommunicatie*) is responsible for exchange of data via an IT infrastructure.

What are the major strategies to ensure quality of care?

At the system level, quality is ensured through legislation governing professional performance, quality in health care institutions, patient rights, and health technologies. In 2014, the National Health Care Institute was established to further accelerate the process of quality improvement and evidence-based practice. The Dutch Health Care Inspectorate is responsible for monitoring quality and safety. Most quality assurance is carried out by providers, sometimes in close cooperation with patient and consumer organizations and insurers. There are ongoing experiments with disease management and integrated care programs for the chronically ill.

In the past few years, many parties have been working on quality registries. Most prominent among these are several cancer registries and surgical and orthopedic (implant) registries. Mechanisms to ensure the quality of care provided by individual professionals include reregistration of specialists contingent upon compulsory continuous medical education; regular on-site peer assessments by professional bodies; and professional clinical guidelines, indicators, and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programs. Furthermore, quality of care is supposed to be enhanced by selective contracting (e.g., volume standards for breast cancer treatment).

In 2014, a few pay-for-performance pilot programs featuring quality targets were initiated but, as yet, specifics about the programs and effects are unknown. Moreover, in the new GP funding model, part of the old budget is preserved for pay-for-performance projects. Patient experiences are also systematically assessed and, since 2007, a national center has been working with validated measurement instruments in an approach comparable to that of the Consumer Assessment of Healthcare Providers and Systems, in the United States. Although progress has been made, public reporting on quality of care and provider performance is still in its infancy in the Netherlands. To stimulate the transparency movement, the Ministry of Health called 2015 the "year of transparency."

What is being done to reduce disparities?

Health disparities are considerable in the Netherlands, with up to seven years of difference in life expectancy between the highest and lowest socioeconomic groups. Smoking is still a leading cause of untimely death. The current government does not have a specific policy to overcome health disparities. In 2013, government decided to include diet advice and smoking cessation programs in the statutory benefits package. Every four years, health access variations are measured and published in the *Dutch Health Care Performance Reports*.

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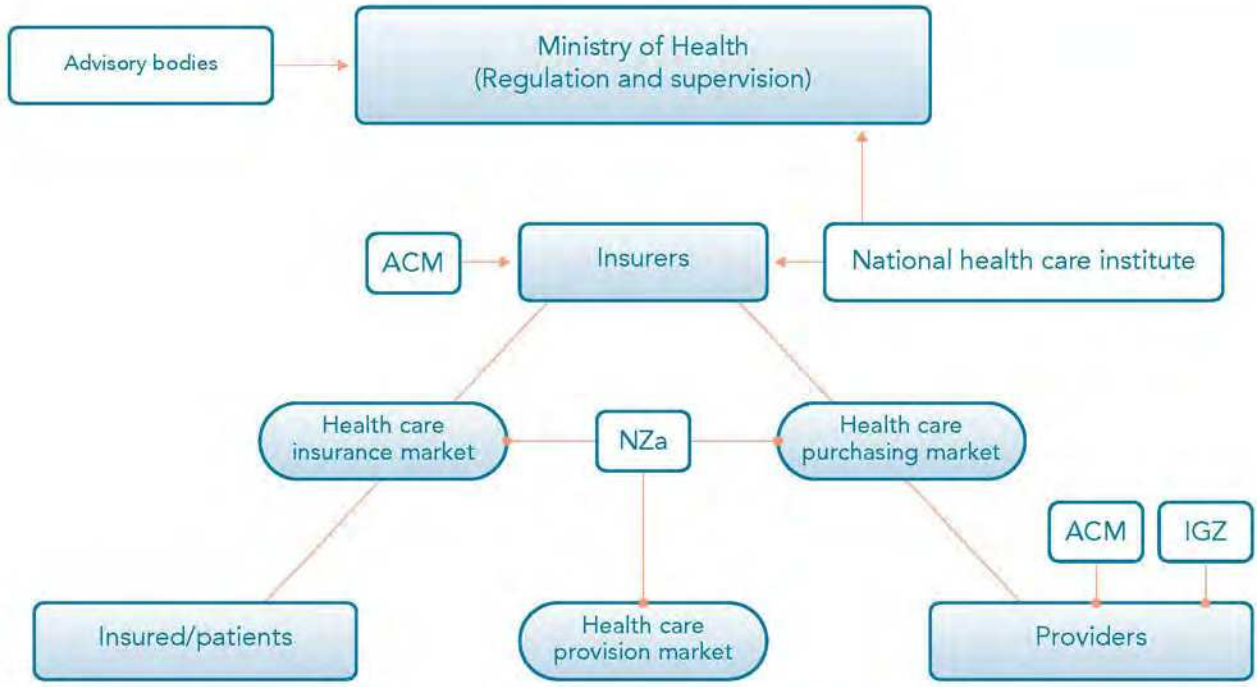
Organization of the Health System in the Netherlands



Source: J. Wammes, P. Jeurissen, and G. Westert, Radboud University Medical Center, 2014.

What is being done to promote delivery system integration and care coordination?

A bundled-payment approach to integrated chronic care is applied nationwide for diabetes, COPD, and cardiovascular risk management. Under this system, insurers pay a single fee to a principal contracting entity—the care group (see above)—to cover a full range of chronic disease services for a fixed period. The bundled-payment approach supersedes traditional health care purchasing for the condition and divides the market into two segments—one in which health insurers contract care from care groups, the other in which care groups contract services from individual providers, each with freely negotiable fees (Struijs & Baan, 2011). To head off potential additional coordination problems and better reach vulnerable populations, the role of district nurses is currently being strengthened.

What is the status of electronic health records?

Authorities are working to establish a central health information technology network to enable providers to exchange information. All Dutch patients have a unique identification number (*burgerservicenummer*). Virtually all general practitioners have a degree of electronic information capacity—for example, they use an electronic health record and can order prescriptions and receive lab results electronically. At present, all hospitals have an electronic health record.

Electronic records for the most part are not nationally standardized or interoperable between domains of care. In 2011, hospitals, pharmacies, after-hours general practice cooperatives, and organizations representing general practitioners set up the Union of Providers for Health Care Communication (*De Vereniging van Zorgaanbieders voor Zorgcommunicatie*), responsible for the exchange of data via an IT infrastructure named AORTA; data are not stored centrally. Patients must approve their participation in this exchange and have the right to withdraw; access to their own files is granted by providers upon request.

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How are costs contained?

The main approach to controlling costs relies on market forces while regulating competition and improving efficiency of care. In addition, provider payment reforms, including a shift from a budget-oriented reimbursement system to a performance- and outcome-driven approach, have been implemented.

Cost containment was one of the most significant subjects of public debate surrounding the 2012 elections. The most recent figures indicate that expenditure growth has fallen significantly, to 1.8 percent in 2014.

The pharmaceutical sector is generally considered to have contributed significantly to the decrease in spending growth. Average prices for prescription drugs declined in 2014, although less than in previous years. Reimbursement caps for the lowest-price generic have contributed to the decrease in average price. Reimbursement for expensive drugs has to be negotiated between hospital and insurer. There is some concern that this and other factors may limit access to expensive drugs in the near future.

The annual deductible, which accounts for the majority of patient cost-sharing, more than doubled between 2008 and 2015, from EUR170 (USD206) to EUR375 (USD454). There are some worries that this increase has led to greater numbers of people abstaining from or postponing needed medical care.

Health technology assessment is gaining in importance and is used mainly for decisions concerning the benefit package and the appropriate use of medical devices.

In 2013, an agreement signed by the Minister of Health, all health care providers, and insurers set a voluntary ceiling for the annual growth of spending on hospital and mental care. When overall costs exceed that limit, the government has the ability to control spending via generic budget cuts. The agreement included an extra 1 percent spending growth allowance for primary care practices in 2014 and 1.5 percent in 2015–17, provided they demonstrate that their services are a substitute for hospital care.

Cost containment is most severe in long-term care. People with lower care needs are no longer entitled to residential care. In addition, the devolution of services to the municipalities was accompanied by substantial cuts to the available budgets (on average almost 10%).

What major innovations and reforms have been introduced?

After years of rapid spending growth, long-term care as of January 2015 is fundamentally reformed. The reform program's main goals were to guarantee fiscal sustainability and universal access in the future and to stimulate greater individual and social responsibility. The new structure seems to be up and running, but its effects as yet are unknown, and future amendments may be needed.

In curative health care, market reform and regulated competition remain somewhat controversial. The government, determined to continue stimulating competition between insurers and providers, undertook some measures to that effect, such as requiring insurers and providers to assume greater financial risk. In December 2014, however, the Dutch Senate rejected a new policy proposal restricting free provider choice in specific insurance policies. The accessibility of expensive drugs has rapidly become a prominent issue in 2015.

As of the date of this report, the Health Insurance Act has undergone two evaluations. The latest evaluation pointed to an imbalance of power, with providers having an advantage over insurers.

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The New Zealand Health Care System, 2015

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What is the role of government?

Beginning with passage of the Social Security Act in 1938, a consensus has developed in New Zealand that government has a fundamental role in providing for the population's health care needs. At the same time, there is continued public support for a private sector role as well. Government plays a central role in setting the policy agenda and service requirements for the health system and in setting the annual publicly funded health budget.

Responsibility for planning, purchasing, and providing health services and disability support for those over age 65 lies with 20 geographically defined district health boards (DHBs), each of which comprises seven locally elected members and up to four members appointed by the Minister of Health. These boards pursue government objectives, targets, and service requirements while operating government-owned hospitals and health centers, providing community services, and purchasing services from nongovernment and private providers.

Who is covered and how is insurance financed?

Publicly financed health care: All permanent residents have access to a broad range of services, which are largely publicly financed through general taxes. Nonresidents, such as tourists and illegal immigrants, are charged the full cost of services by public health care providers, unless treatment is related to an accident, in which case they are covered by a no-fault accident compensation scheme.

Total health spending was 9.5 percent of GDP in 2013 (OECD, 2015). Public spending, generated through general taxes, accounted for 79.8 percent of total spending.

Privately financed health care: Private health insurance is offered by a variety of organizations, from nonprofits and "Friendly Societies" to for-profit companies, and accounts for about 5 percent of total health expenditure. It is used mostly to cover cost-sharing requirements, elective surgery in private hospitals, and private outpatient specialist consultations; private coverage also often affords faster access to nonurgent treatment. About one-third of the population has some form of private insurance, purchased predominantly by individuals.

What is covered?

Services: The publicly funded system covers preventive care; inpatient and outpatient hospital services; primary care via private providers (excluding services such as optometry, adult dental services, orthodontics, and physiotherapy); inpatient and outpatient prescription drugs included in the national formulary (see below); mental health care; dental care for schoolchildren; long-term care; home help; hospice care; and disability support services. Government sets an annual overall budget and benefits package, based largely on political priorities. It also sets national requirements for publicly funded services, to be implemented by the 20 DHBs. Rationing and prioritization are applied largely to nonurgent services, and vary by DHB.

Cost-sharing and out-of-pocket spending: Out-of-pocket payments, including both cost-sharing and other costs paid directly by private households, accounted for approximately 12.6 percent of total health expenditures in 2014 (OECD, 2015), with the largest portion going to outpatient services. There are no deductibles in the public sector, although copayments are required for general practitioner (GP) services and many nursing services

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provided in GP clinics. The average copayment for a GP consultation for an adult ranges from NZD15 to NZD45 (USD10–USD31), but copayments vary significantly, as there are no limits to these set by GPs. An exception applies to the one-third of New Zealanders residing in low-income areas, where a higher annual per-patient capitation rate is paid and, in return, patient copayments are capped at NZD17.50 (USD12.00) per visit.[1] GP copayments fell during the period 2002–2008, when there were significant increases in government funding for primary care, but copayments have been increasing since then.

Copayments are also required for drugs prescribed by GPs and private specialists (NZD5.00 [USD3.40] per item); after copayments are made for 20 prescriptions per family per year, they are free. There are no charges for residents treated in public hospitals, although there are some user charges, such as those for crutches and other aids supplied upon discharge. There are various means-tested subsidies, resulting in some copayments for long-term care, as discussed in the relevant section below.

Safety net: Primary care is mostly free for children age 13 and under, and is subsidized for the 98 percent of the population enrolled in the networks of self-employed providers known as primary health organizations (PHOs). PHOs include general practitioners (GPs), practice nurses, and allied practitioners. Additional PHO funding and services are available for treating people with chronic conditions and for improving access to care for groups with greater health needs. A "high-use health card" is also available, upon application, to patients who have had more than 12 GP visits in a year. Subsequent capitation payments for those patients are set at a higher level to reflect this high-utilization pattern, although patients continue to make copayments.

How is the delivery system organized and financed?

Primary care: The ratio of GPs to specialists is about 2:3. GPs act as gatekeepers to specialist care. They are usually independent, self-employed providers compensated by a capitated government-determined subsidy, paid through PHOs and accounting for about half their income; patient copayments, set by individual GPs, provide the rest. An average of 3.48 GPs work together in each practice, assisted by practice nurses. Nurses are salaried and paid by GPs, and have a significant role in the management of long-term conditions (e.g., diabetes), incentivized by specific government funding for chronic care management. Patient registration is not mandatory, but GPs and PHOs must have a formally registered patient list to be eligible for government subsidies. Patients enroll with a GP of their choice; in smaller communities, choice is often limited.

PHOs receive additional per-capita funding to improve access, especially for people who can least afford primary care, and to aid in promoting health, coordinating care, and providing additional services for people with chronic conditions. In some cases, this support has led to the development of multidisciplinary care teams that may include specialists, such as nutritionists or podiatrists; this trend is being further driven by new alliance arrangements (outlined below). PHOs also receive up to 3 percent additional funding that is handed on to GPs if they reach targets for cancer, diabetes, and cardiovascular disease screening and follow-up, and also goes toward vaccinations. Most GPs belong to an organized network that provides management and other clinical support services. The larger networks represent several hundred GPs each.

Outpatient specialist care: Most specialists are employed by DHBs and salaried for working in a public hospital. However, they are also able to work privately in their own clinics or treat patients in private hospitals, where they are paid on a fee-for-service basis. The impact of this "dual practice" on the public sector remains under-researched and under-debated (Gauld, 2013). Many specialists are based in multispecialty clinics but work independently, renting their office from the clinic. Private specialists are concentrated in larger urban centers and set their own fees, which vary considerably; insurance companies have little, if any, control over those fees, although insurers will pay only up to a maximum amount, meaning that patients pay any difference. In public hospitals, patients generally have limited choice of specialists.

[1] Please note that, throughout this profile, all figures in USD were converted from NZD at a rate of about 1.47 NZD per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015b) for New Zealand.

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Administrative mechanisms for paying primary care doctors and specialists: As noted above, GPs' income is derived from government subsidies, which include payments from the Accident Compensation Corporation (ACC), and from patient copayments. Some patients subscribing to private insurance may be eligible to claim for the copayment. Patients pay the full cost of private specialist visits up front, unless the service is funded by ACC or by private insurance. In the latter case, patients may seek reimbursement from their insurer, or there may be no direct patient charge if a specialist or private hospital holds a contract with the insurer.

After-hours care: GPs are required in their funding contracts to provide after-hours care or to arrange for its provision, and receive a separate government subsidy for doing so, which is higher per patient than the general capitation rate. In rural areas and small towns, GPs work on call; in some of these areas, a nurse practitioner with prescribing rights may provide first-contact care. In cities, GPs tend to provide after-hours service on a roster at purpose-built, privately owned clinics in which they are shareholders. These facilities employ their own support staff such as nurses, but patients usually see a GP in the first instance. Patient charges at these clinics are higher than those for services during the day (although 95% of children under age 13 can have access to free GP after-hours services). Consequently, some patients will visit a hospital emergency department instead, or avoid after-hours service altogether. A patient's usual GP routinely receives information on after-hours encounters. The public also has access to the 24-hour, seven-day-a-week phone-based "Healthline," staffed by nurses who provide advice in response to general health questions. "Plunketline" provides a similar service for child and parenting problems.

Hospitals: New Zealand has a mix of public and private hospitals, but public hospitals constitute the majority, providing all emergency and intensive care. Public hospitals receive a budget from their owners, the DHBs, based on historic utilization patterns, population needs projections, and government goals in areas such as elective surgery. The budget includes the costs of health professionals and other staff, who are all salaried. Within a DHB hospital, the budget tends to be allocated to the various inpatient services using a case-mix funding system. A proportion of DHB funding for elective surgery is held by the Ministry of Health, and payments are made upon delivery of surgery. Certain areas of funding, such as mental health, are "ring-fenced"—the DHB must spend the money on a specified range of inputs.

Private-hospital patients with complications are often admitted to public hospitals, in which case the costs are absorbed by the public sector. Public-hospital services are provided largely by consultant specialists, specialist registrars, and house surgeons.

Mental health care: Most people get access to mental health care through primary mental health services in the community, often through their GP, who will then coordinate any referred services, but also through school-based health services and community services provided by nongovernment agencies, which are all publicly funded. DHBs deliver a range of mental health services (including secondary services), such as forensic, acute inpatient, and community-based services, and provide support to primary care providers; they also fund nongovernment providers of community-based services. Private provision is limited.

Long-term care and social supports: DHBs fund long-term care for patients on the basis of needs assessment, age, and a means test. They fund services for those over age 65 and those "close in age and interest" (e.g., people with early-onset dementia or a severe age-related physical disability). Those eligible receive comprehensive services including medical care; many older or disabled people receive home care. Some younger disabled recipients opt for individual budgets to arrange their own home care. Respite care is available to relieve informal or family caregivers, and in some circumstances there is ongoing financial support. Residential facilities, mostly private, provide long-term care. DHBs also provide hospital- and community-based palliative care. A network of hospices provides end-of-life care, with approximately 70 percent of funding coming from DHBs and the remainder through fundraising. Palliative care is also provided in the community.

Long-term care subsidies for older people are means-tested. Residents with assets over a given national threshold pay the cost of their care up to a maximum contribution. Residents with assets under the allowable threshold contribute all their income, except for a small personal allowance. DHBs cover the difference between the resident's payments and the contract price for residential care. For people in their own homes, household

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management (e.g., cleaning), which accounts for less than one-third of home support funding, is income-tested. Personal care (e.g., showering) is provided free of charge. Home care services are all provided by nongovernment agencies.

What are the key entities for health system governance?

As the health system is primarily public, government-funded and -appointed entities dominate governance structures. Some, like the health and disability commissioner (whose function is to champion consumers' rights in the health sector), sit at arm's length from the central government. Others are "crown entities," with their own boards, and are required to follow government policy through letters of expectation. Key national arrangements, all of which have a role in providing information to, and engaging with, the public, are:

- the Ministry of Health, which has overall responsibility for the health and disability system. The ministry acts as the Minister of Health's principal advisor on health policy and maintains a role as funder, monitor, purchaser, and regulator of health and disability services. While it sets capitation rates paid to GPs, it has no role in regulating patient copayments.
- the National Health Board (NHB), which aims to improve the quality, safety, and sustainability of health care by actively engaging with clinicians and the wider health sector. The NHB provides advice to the health minister and the director-general of health on all of the aforementioned matters. It has two subcommittees: the Capital Investment Committee, which provides advice on matters relating to capital investment and infrastructure in the public health sector, in line with the government's service planning direction; and the National Health IT Board, which provides advice on the implementation and use of IT systems across the sector.
- NZ Health Partnerships, established in July 2015 to support DHBs in delivering shared services and reduce costs by identifying opportunities for savings in administrative, support, and procurement.
- the Pharmaceutical Management Agency of New Zealand, which assesses the effectiveness of drugs, distributes prescribing guidelines, and determines inclusion of drugs on the national formulary (with relative cost-effectiveness being one of nine criteria for inclusion). In addition, certain medical devices have been added to its schedule (Gauld, 2014). As of late 2015, a new set of "factors for consideration" will be used to underpin decisions: need; health benefit; costs and savings; and suitability.
- the Health Quality and Safety Commission, which ensures that New Zealanders receive the best health and disability care possible given available resources. It is also working toward what is known as the New Zealand "triple aim"—improved quality, safety, and experience of care; improved health and equity for all populations; and better value for public health system resources.
- the National Health Committee (NHC), which advises government on priorities for new and existing health technologies. All new diagnostic and nonpharmaceutical treatment services and significant expansions of existing services are referred to the NHC for evaluation and advice. The committee also provides advice on what technologies are obsolete or no longer provide value for money.

What are the major strategies to ensure quality of care?

The aforementioned health and disability commissioner investigates patient complaints, reports directly to Parliament, and has been active in promoting quality and patient safety.

DHBs are held formally accountable to government for delivering efficient, high-quality care in hospitals, as measured by the achievement of targets across a range of indicators. These include six "health targets," published quarterly, that aim to stimulate competition among DHBs and are enforced by financial sanctions if not met. In addition, DHB performance with regard to waiting times, access to primary care, and mental health outcomes is publicly disclosed. Also publicly reported are data comparing the performance of PHOs,

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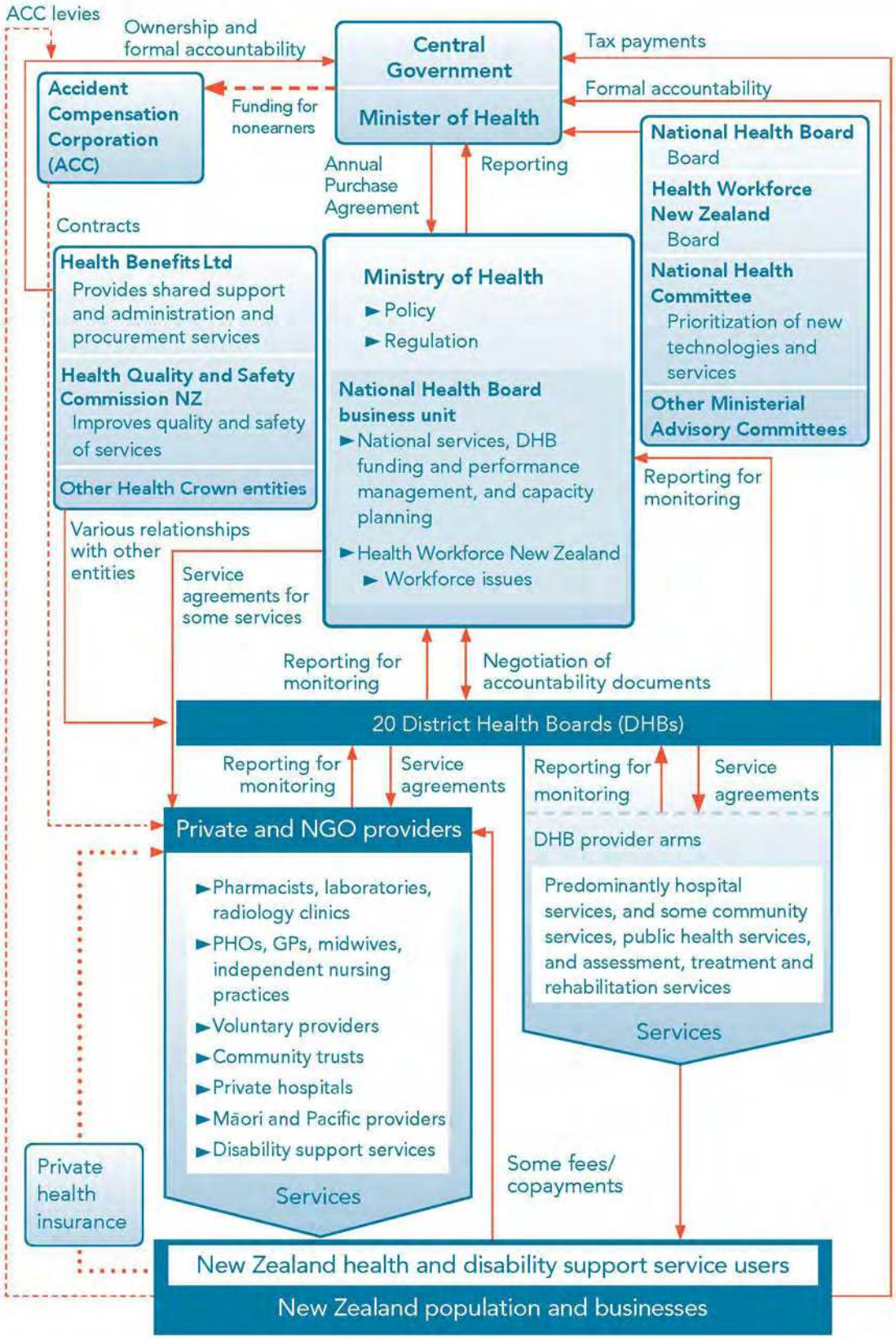
Organization of the Health System in New Zealand



Source: New Zealand Ministry of Health, 2015.

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including such information as screening rates for chronic diseases. Data on individual doctors' performance, however, are not routinely made available. As noted above, PHOs and GPs receive performance payments for achieving various targets.

DHBs and individual GP clinics and networks run various chronic disease management programs. There are national registries for some diseases, including diabetes, cardiovascular disease, and cancers. Since 2014, public hospitals have been required to conduct a nationally standardized survey of a random sample of patients and to submit data to the Health Quality and Safety Commission, which publicizes the findings.

Certification by the Ministry of Health is mandatory for hospitals, nursing homes, and assisted-living facilities, which must meet published and defined health and disability standards. All practicing health professionals must be certified annually by the relevant registration authority (e.g., for doctors, the Medical Council of New Zealand), which has ongoing responsibility for ensuring professional standards and providing accreditation. Registration authorities supervise individual professionals where appropriate.

The Health Quality and Safety Commission is intended to increase the focus on quality and coordinate the varied approaches to quality improvement across DHBs, such as those aimed at improving the patient journey, ensuring safer medication management, reducing rates of health care–associated infection, and standardizing national incident reporting. Other initiatives include the ongoing development of the Atlas of Healthcare Variation (an online tool aimed at highlighting variations in the provision and use of services by geographic area); a series of standard quality and safety indicators for DHBs based on routinely collected data; a program for consumer involvement in service design; and advice for DHBs on how to prepare annual "Quality Accounts," required since 2012–2013. Much like a financial account, Quality Accounts report on how the DHB has approached quality improvement, including descriptions of key initiatives and their results. In 2013, the commission launched a national patient safety campaign, Open for Better Care, focused on reducing the negative consequences associated with falls, surgery, health care–associated infections, and medications.

The National Health Board is also working on quality improvement in DHBs, with particular emphasis on management systems, clinical services, and patient pathways. "Clinical governance" has been implemented in most DHBs, meaning that management and health professionals are assuming joint accountability for quality, patient safety, and financial performance.

What is being done to reduce disparities?

Disparities in health are a central concern in New Zealand, as Maori and people of Pacific Island origin have shorter life expectancies than other New Zealanders (by seven and six years, respectively), and reducing disparities is a policy priority (Ministry of Health, 2013). Maori and Pacific people are also known to experience greater difficulty in gaining access to health services, and data describing disparities are routinely collected and publicly reported.

Through much of the 2000s, a multisector policy approach saw investments in housing, education, and health, as DHBs and primary health organizations were required to develop strategies for reducing disparities. Many PHOs were created especially to serve Maori or Pacific populations.

The post-2008 government has focused on specific initiatives such as Whanau Ora, a policy designed to integrate health and social services for disadvantaged Maori. The aim has been to develop coordinated, multiagency approaches to service provision and foster joint responsibility for outcomes.

What is being done to promote delivery system integration and care coordination?

Larger Integrated Family Health Centers (IFHCs) are developed in line with the "Better, Sooner, More Convenient" government policy, which aims to improve access to integrated care provided by DHBs and PHOs

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by establishing more convenient locations for patients (outside of hospital settings) and by emphasizing chronic disease management (Ryall, 2008; Ministerial Review Group, 2009). These centers provide comprehensive primary care and care coordination, after-hours services, and some minor elective procedures for an enrolled population. New facilities will see services and providers colocated, or coordination of services improved, with funding from both primary care budgets and DHBs.

Patients enrolled in PHOs have a medical home, but PHOs vary widely in size, performance, and activities. The highest-performing among them provide a model that, if nationally emulated, would result in all enrollees having a fully functional, multidisciplinary medical home, although institutional barriers to integrating primary and hospital care would remain.

The New Zealand government is accelerating the drive for clinical integration to create a more patient-centered health system. It is also ensuring that all DHBs' annual plans include proposals for integration. These directions have been propelled by a new PHO contract in place since mid-2013 that requires PHO–DHB alliances modeled after Integrated Family Health Center pilot programs. There is considerable scope for these alliances to integrate health and social services (see below), and there is a gradual move toward pooled funding streams. Some specialized providers contracted by the government that focus on vulnerable populations, such as Maori and Pacific people, work to coordinate health and social services (e.g., Whanau Ora, described above).



What is the status of electronic health records?

New Zealand has one of the world's highest rates of information technology (IT) use among primary care physicians, with almost 100 percent uptake (Schoen et al., 2012). The government's goal is universal electronic access to a core set of residents' personal health information by 2014. However, despite some progress, that goal is unlikely to be met, owing to the complexity of implementing a national patient portal. Clinicians and vendors are working together on numerous projects: there is a larger emphasis on supporting and enabling integrated care, and a shift toward regional investment decisions and solutions. However, challenges with legacy systems remain.

Increasingly, primary care IT systems provide services such as structured electronic transfer of patient records, electronic referrals, decision support tools with patient safety features, and patient access to health information in a secure environment.

In the near future, there will be more emphasis on facilitating secure sharing of patient information among community, hospital, and specialist settings, including common clinical information; providing all consumers with an online view of their information; and supporting the development of shared-care plans (in which a number of health professionals are involved in a person's care). However, current levels of interoperability are limited.

The National Health IT Board works with a number of sector groups and receives advice from, among others, clinicians, consumers, and vendors. The Health Information Standards Organisation supports and promotes the development and use of standards to ensure interoperability between systems. Every person who uses health and disability support services has a unique national health number, facilitating the process of building interoperable systems.



How are costs contained?

The financial sustainability of publicly funded health care is a top government priority. To support this goal, government has implemented a range of measures, including four-year planning to align expenditure with priorities over a longer period and improving regional collaboration to drive efficiencies. All new proposals must be integral to a four-year plan and demonstrate their fit with the strategic direction of the health sector.

Cost control in DHBs has been closely monitored by the Ministry of Health, with a significant reduction in deficits over the last five years, from NZD154.8 million (USD105.4 million) in 2008–2009 to NZD7.4 million (USD5.0 million) in 2013–2014 (personal communication, Ministry of Health). These reductions are achieved

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largely through efficiency gains and cuts in spending on staff, services, and equipment. As public hospitals are essentially free of charge, there is no mechanism to shift costs to patients. There have been experiments with shared-savings arrangements in the past, with contracted providers such as GP networks.

The National Health Committee prioritizes health technologies and provides advice as to which technologies no longer offer value for money, increasingly using comparative-effectiveness research in evaluation.

The Pharmaceutical Management Agency uses mechanisms such as reference pricing and tendering to set prices for publicly subsidized drugs dispensed through community pharmacies and hospitals (Gauld, 2014). If patients prefer unsubsidized medicines (and if there are no clinical indications that these would be more effective), they pay the full cost. Such strategies have helped to drive down pharmaceutical costs and to keep drug expenditure per capita the fourth-lowest in the OECD in 2012 (OECD, 2014).

What major innovations and reforms have been introduced?

Reforms over the past two years have been mostly adjustments to existing arrangements, with one standout. In mid-2013, a new national Primary Health Organisation contract was issued, with new minimum PHO standards and a requirement that DHBs and PHOs enter into alliances. The rationale for the requirement was to link together the parts of the health system—GPs and public hospitals in particular—that operate largely separately but with common populations in a region. The impetus for forming these alliances is the government's increasing concern over chronic disease and care for complex patients, and its desire to better support patients and their providers in primary care settings.

These alliances reflect an important shift in the governance model and structures for designing and delivering health services in New Zealand. Each alliance must take a whole-system approach, bringing together clinical leaders, managers, and community representatives from across the local health system to consider health services from a patient perspective. An alliance's focus is primarily integration, with the alliance setting service priorities, generating consensus on how those priorities will be met, and then sharing financial and other resources to facilitate implementation. Many alliances are creating further clinically led "service level alliances" targeting different areas of care design; many also govern health pathway development, which is rapidly expanding across New Zealand (Gauld, 2014b).

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The Norwegian Health Care System, 2015

Anne Karin Lindahl
Norwegian Knowledge Centre for Health Services



What is the role of government?

Government is responsible for providing health care to the population. Norway's 428 municipalities are responsible for providing primary health and social care, with the Ministry of Health playing an indirect role, mainly through legislation and funding mechanisms. The ministry plays a direct role, however, in specialist care, through its ownership of hospitals and provision of directives to the boards of regional health care authorities (RHAs), as well as through legislation and funding.

Who is covered and how is insurance financed?

Publicly financed health care: Total health expenditure represented 9.2 percent of GDP in 2014, which is about the average for countries in the Organisation for Economic Co-operation and Development (OECD). But Norway ranks among the highest in the OECD in terms of absolute expenditure per capita (NOK56,400, or USD5,965) in 2014) (Statistics Norway, 2015).[1]

The nationally managed and financed health system, providing more than 95 percent of all health care, is built on universal coverage and on the principle of equal access for all regardless of socioeconomic status, ethnicity, and area of residence. It is financed through national and municipal taxes. Social security contributions finance public retirement funds, sick leave payment, and reimbursement of extra health care costs for some patient groups.

For acute hospitalization, there is no private alternative.

Through common agreements, European Union residents and other legal residents have the same access to health services as Norwegians. Other visitors are charged in full. Undocumented adult immigrants have access only to emergency acute care, while undocumented children receive the same care as citizens.

Private health insurance: Private health insurance is provided by for-profit insurers and purchased for quicker access to examinations and care but also for choice among private providers. Private health insurance accounts for less than 5 percent of planned services. About 8 percent of the population (or nearly 15% of the workforce) have some kind of private insurance. About 92 percent of policies are paid for by an employer (Finans, Norge 2014).

What is covered?

Services: Parliament determines what is covered, although there is no defined benefits package except for new and costly treatments and technologies (see below). In practice, national health care covers planned and acute primary, hospital, and ambulatory care, rehabilitation, and outpatient prescription drugs on the formulary (the "blue list"). It also covers dental care services for children up to 18 years of age and other prioritized groups, such as people with rare diseases or chronic diseases that increase the risk of dental problems, patients with chronic mental disabilities, and patients in permanent nursing homes. Dental care for 19-to-20-year-olds and dental orthopedics (braces) for children are partially covered. Nonmedical eye care, aesthetic surgery, and complementary medicine are not covered.

[1] Please note that, throughout this profile, all figures in USD were converted from NOK at a rate of about NOK9.45 per USD, the 2014 purchasing power parity for GDP reported by OECD (2015) for Norway.

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Primary, preventive, and nursing care are organized at the local level by municipalities. The municipality, often in cooperation with the county, decides on public health initiatives or campaigns to promote a healthy lifestyle and reduce social health disparities. Preventive services for mental health are directed toward children and adolescents through the school system. Psychological care for children under the age of 18 is fully covered. Primary care for mental health is provided by general practitioners (GPs) and municipal psychologists. Long-term care, including palliative end-of-life care, is provided on the basis of need, either at home or in nursing homes. There are few designated hospice facilities. The substantial government funding for municipalities is generally not earmarked, and budgets are set locally, but provision of some services is statutory, particularly those related to pediatric and long-term care.

Cost-sharing: GP and specialist visits, including outpatient hospital care and same-day surgery, require copayments (NOK141 [USD15] and NOK320 [USD34] per visit in 2015, respectively), as do physiotherapy visits (in varying amounts), covered prescription drugs (up to NOK520 [USD55] per prescription), and radiology and laboratory tests (NOK227 [USD24] and NOK50 [USD5]). Public providers cannot charge patients more than these amounts, except for bandages and other supplies. Consultations for antenatal and postnatal follow-up, for prevention and treatment of transmittable diseases for particularly vulnerable individuals, and treatment of sexually transmitted diseases are also exempt from copayments. Hospital admissions and inpatient treatment are free. Out-of-pocket payments finance about 14 percent of total expenditure.

Home-based and institutional care for older or disabled people require high cost-sharing (up to 85% of personal income), but are means-tested.

Safety net: The major safety net mechanisms are annual caps for out-of-pocket expenditure set by Parliament, above which fees are waived. For 2015, the cost-sharing ceiling for most services is NOK2,105 (USD223). A second ceiling is set at NOK2,675 (USD283) for services such as physiotherapy and certain dental services. Long-term care and prescription drugs outside the "blue list" do not apply toward these ceilings.

Children under the age of 16 receive free treatment and access to essential drugs on the blue list. Pregnant women receive free medical examinations during and after pregnancy. Residents eligible for minimum retirement pension or disability pensions, which amount to about NOK162,000 (USD17,134) per year, receive free essential drugs and nursing care. Individuals with specified communicable diseases, including HIV/AIDS, and patients with work-related injuries receive free medical treatment and medication. Taxpayers with high expenses (above NOK5,880, or USD622) as a result of permanent illness receive a tax deduction. "Basic benefits" (NOK653–NOK2,264, or USD69–USD239 per month) may be provided, upon application, to patients who regularly incur additional expenses due to permanent illness, injury, or disability.

How is the delivery system organized and financed?

Primary care: Municipalities provide primary care in accordance with current legislation, government directives, and quality requirements set by the Directorate for Health.

The "regular GP scheme," whereby people register with one general practitioner (GP), covers 99.4 percent of the population. There were an average of 1,132 patients per GP in 2014. Patients may change their GP twice a year. GPs function as gatekeepers, as referral to specialist treatment by a GP is required for coverage.

There are 2.4 specialists in hospitals or ambulatory care for every practicing primary care physician (Den norske legeforening, 2015). Financial incentives encourage physicians to certify as a specialized GP and to see many patients per day.

Municipalities contract with individual GPs, who receive a combination of capitation from the municipalities (35% of income), fee-for-service from the Norwegian Health Economics Administration (Helfo) (35%), and out-of-pocket payments from patients (30%). GP financing is determined nationally by negotiation between the Ministry of Health and the Norwegian Medical Association. In the fee-for-service scheme, there are fees provided for taking part in coordination of care and individual planning, but they are relatively low. There

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is also a financial incentive for medication reconciliation. Most GPs are self-employed, and 10 percent are salaried municipal employees (Helsedirektoratet, 2014). The average salary is estimated to be NOK750,000 (USD79,325), but may be substantially higher for full-time practitioners. GP practices typically comprise two to six physicians and employ nurses, lab technicians, and secretaries. Many municipalities have multidisciplinary outreach teams for mental health, staffed by health care workers employed by the municipalities.

Specialist care: The four RHAs, which are state-owned corporations that report to the Ministry of Health, are responsible for supervising specialist inpatient somatic and psychiatric care, as well as treatment for alcohol and substance abuse. The ministry provides RHAs' budgets, and issues an annual document instructing the RHAs as to aims and priorities.

Outpatient specialist care is provided both by hospitals and by self-employed specialists. Hospital-based specialists are salaried. Privately practicing specialists contracted by an RHA are paid a combination of annual lump sums, based on the type of practice and number of patients on the list (about 35%); fee-for-service payments (about 35%); and patients' copayments (about 30%). The annual lump sum and the out-of-pocket fees are set by government, and the fee-for-service payment scheme is negotiated between government and the Norwegian Medical Association. In principle, patients have a choice of specialist, although in practice specialist availability varies by geographic location. In the more densely populated areas, clinics with multidisciplinary specialists have emerged during the last few years and seem to be increasing in number. Hospital-employed specialists cannot see private patients at the hospital, but may practice privately after hours, on their own time. Specialists with an RHA contract can charge patients only the specified out-of-pocket fee. Those who do not receive public financing are neither regulated nor subject to the out-of-pocket expenditure caps.

Patient out-of-pocket payments: Patients pay their out-of-pocket fee directly to the provider. If they reach the first safety net ceiling, it is automatically registered and copayments are made directly to the provider by Helfo. For the second ceiling, patients need to submit an application with proof of payment of the out-of-pocket costs. Once it is approved, patients receive a certificate and are not charged further copayments.

After-hours care: After-hours emergency primary care services are the responsibility of the municipalities, whose contracts with GPs include after-hours emergency services on rotation. The municipalities provide offices, equipment, and assistance, and pay the GPs a small fee. Other payments are provided by the national fee-for-service system and out-of-pocket payments from patients. The organization of after-hours services varies according to the size of the municipality. The more densely populated municipalities have walk-in centers where nurses triage patients and answer calls, and several doctors see patients all through the day and night. In smaller municipalities, patients call an after-hours phone number and speak with a nurse, who calls the GP if the patient needs to be seen. As of September 2015, a common national phone number was launched for all of these public primary care after-hours services (legevakt). In larger cities, as a supplement to the public services, there are a few privately owned and run after-hours clinics where patients pay in full.

There is variation as to whether information from emergency visits is shared with patients' regular GPs. There is an emergency phone number patients can call for urgent ambulance services, but no national medical advice line. Patient cost-sharing and provider fees are slightly higher for after-hours emergency services.

Acute-care hospital services are the responsibility of RHAs. Patients need an acute-care referral to these services by a primary care physician or may, in particular cases (accidents, suspected heart attack, stroke, etc.) have access directly via ambulance.

Hospitals: Public hospital trusts are state-owned, formally registered as legal entities with an executive board (approved and partly appointed by the Ministry of Health), and governed as publicly owned corporations. A few are privately owned, mostly by nonprofit humanitarian organizations, and mostly provide publicly funded services as part of RHA plans for providing acute care. The for-profit hospital sector is small, providing less than 1 percent of specialist services in 2013 (Samdata, 2013). For-profit hospitals do not provide the full range of services, and do not offer acute services. A part of their services may be publicly funded, but the proportion varies, from almost none to 85 percent in 2013.

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Patients are free to choose a hospital for elective services but not for emergency care. Public hospitals are financed through RHAs—for somatic services with a block grant (50%), and with an activity-based portion (50%, based on diagnosis-related group, or DRG). The RHAs are free to decide how the hospitals are paid, but all four have chosen the same funding mechanism for somatic services; 50 percent as block grant and 50 percent based on DRG. All health personnel are salaried, including doctors, and all payments, public and private, include all services.

Mental health: Mental health care is provided by GPs and by other providers (psychologists, psychiatric nurses, social care workers) in municipalities. For specialized care, GPs refer patients to private psychologists or psychiatrists, or to a low-threshold hospital (district psychiatric center). These hospitals are dispersed throughout the country. They often include psychiatric outreach teams. More advanced specialized services are organized in the inpatient psychiatric wards of general hospitals or in mental health hospitals. Hospital treatment is provided free of charge, and outpatient services are subject to the same cost-sharing as described above. Hospitals and district psychiatric centers are funded by government block grants through RHAs. The role of private mental hospital care is very small, and includes services for eating disorders, nursing home care for older psychiatric patients, and some psychiatrist and psychologist outpatient practices, mostly contracted by RHAs. The role of private treatment centers for addiction (mainly drugs and alcohol) is more prominent, and funded mostly through contracts with RHAs.

Long-term care: The municipalities are responsible for providing long-term care, and contract also to some extent with private providers. Cost-sharing for institutionalized care is income-based, and is set at 75–85 percent of patients' income, depending on means tests. Home nursing is also provided, if needed. The levels of care at home or in a nursing home are determined by the municipality. Only about 3 percent of nursing homes are private, and for home nursing care, the proportion is even lower. There are a few private providers of home nursing care and other services, which are purchased by patients most often as a supplement to services by public home care. In some densely populated areas, patients can have a choice of home care provider or nursing home, but rarely arrange for services themselves. Very few patients pay individually for full-time private nursing home care. End-of-life care for terminal patients is often provided in particular wards within dedicated nursing homes. There is a system in place for informal carers to apply for financial support from the municipalities.

What are the key entities for health system governance?

The Ministry of Health and Care Services is politically led by the Minister of Health, who ensures that political decisions are translated into practice. This is done through legislation, economic measures, and documents instructing the RHAs and the Directorate for Health and other underlying agencies regarding activities and priorities. The political values conveyed by the annual national budget and the instructions in the annual letter of allocation from the ministry are determinative, and specify provider fees, out-of-pocket payments, and ceilings.

The Directorate for Health is an executive agency and authority subordinate to the ministry. It issues clinical guidelines, maintains the National System for the Introduction of New Health Technologies, coordinates 18 patient ombudsmen, and provides public information on health and health care through the website www.helsenorge.no. The Directorate for Health is not responsible for producing systematic reviews or health technology assessments (HTAs) but rather applies them to decision-making pertaining to the system for new technologies, to guidelines, and to policymaking. From 2014 to 2018, the directorate is also in charge of the secretariat for the National Patient Safety Program. It is responsible overall for setting standards and leading the development and application of health information technology in health care. The Directorate for Health is responsible for fee-setting in the DRG system, and also for the five-year project on quality-based financing. There is no single authority overseeing fee-setting for providers other than hospitals.

The Medicines Agency determines which medications to reimburse. For new drugs, the agency determines whether a prescription drug should be covered (on the blue list) by evaluating its cost-effectiveness in comparison with that of existing treatments; a "green" scheme encourages providers to prescribe lifestyle and

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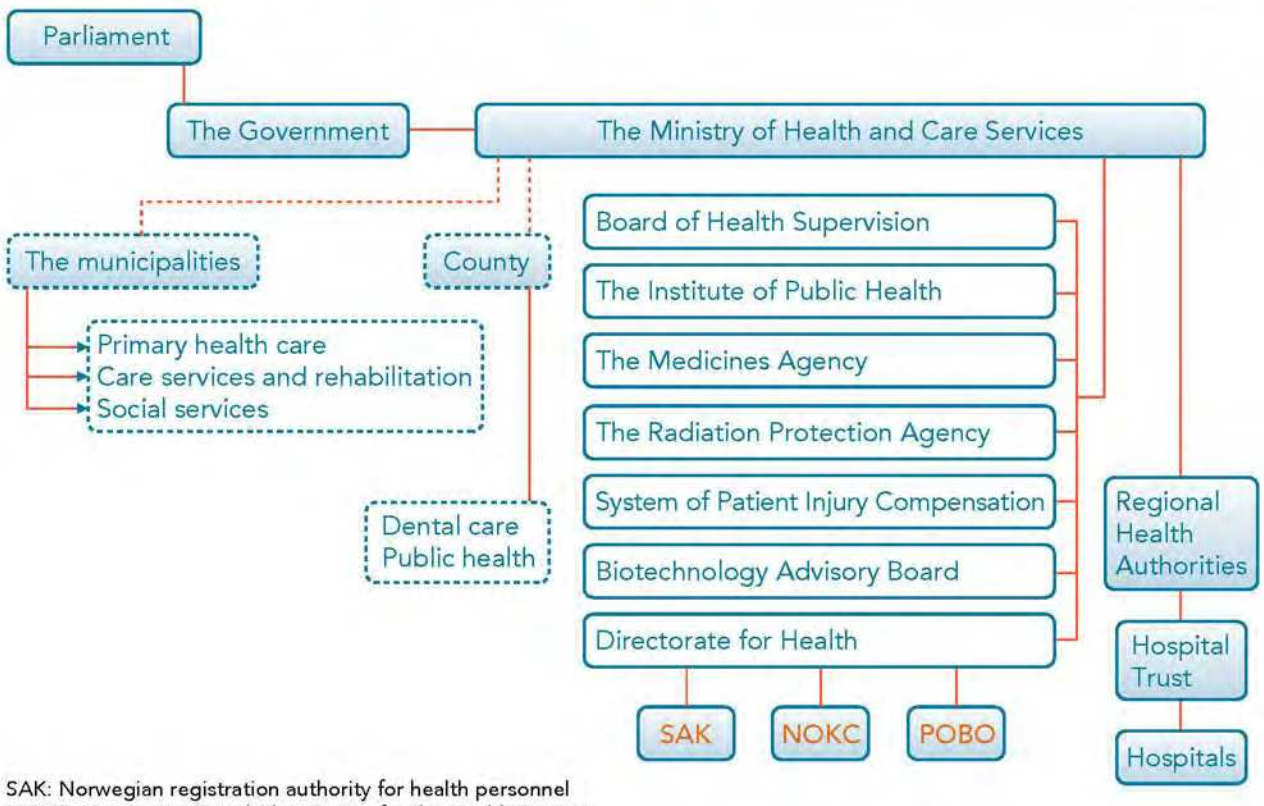
nutrition programs as a first alternative to more expensive preventive medicine. The agency also decides on the maximum price of specific drugs.

The Norwegian Knowledge Center for Health Services, financed by government, produces comparative effectiveness studies (systematic reviews and HTAs) and works with quality and patient safety, quality indicators, and national patient experience surveys. Its HTAs are used by the Norwegian Council for Priority Setting in Health Care and the National System for the Introduction of New Health Technologies. The center also runs the national Reporting and Learning System for adverse events in hospitals.

The Board of Health Supervision is a national public institution organized under the Ministry of Health. The board audits the different areas of the health care system, either systematically on a national basis or individually. An alert system ensures that hospitals alert the board to serious adverse events, and the board may then decide to investigate particular incidents. The board can issue fines to institutions and warnings to health personnel, and can revoke authorization for health care personnel who engage in misconduct.

The Norwegian Institute of Public Health is a center for research on and surveillance of the health status of the population. It provides the Ministry of Health with advice on public health. It is the main authority regarding infection control and infectious disease surveillance. It provides community health profiles regarding prevalence of disease and holds several of the large health registers, including the prescription registry. The institute also assists the prosecuting authorities and the judiciary regarding forensic medicine.

Organization of the Health System in Norway



SAK: Norwegian registration authority for health personnel
NOKC: Norwegian Knowledge Centre for the Health Services
POBO: Health and care services ombudsmen

Source: A. K. Lindahl, Norwegian Knowledge Centre for Health Services, 2015.

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What are the major strategies to ensure quality of care?

The national strategy for quality improvement (2005–15) focuses on efficacy, safety, efficiency, patient-centered care, care coordination, and continuity and equality in access to health care (Directorate for Health, 2005). National evidence-based guidelines are being developed for a number of diseases. For cancer, there is a disease management program, introducing defined "packages" to be delivered to patients. To improve patient safety, there is a five-year national program (2014–18), as well as a national reporting and learning system for adverse events. There are 47 national clinical registries for specific diseases, as well as 15 national health registries. There is no registry for technical devices, but a statutory duty for hospitals to report adverse events, including those involving technical equipment.

The Directorate for Health is in charge of the national program for health care quality indicators. The program includes results from national patient experience surveys. No information is gathered or disseminated regarding results or quality of individual health care professionals' performance.

The Registration Authority for Health Personnel licenses and authorizes all health care professionals and can grant full and permanent approval to those meeting educational and professional criteria. There is no system for reevaluation or reauthorization. The authority issues certificates of specialization to medical doctors, in accordance with specific and transparent requirements. Only the specialization for GPs requires recertification. The Norwegian Board of Health carries out audits of all levels of the health system, including the health care workforce.

RHAs, hospitals, municipal providers and private practitioners are responsible for ensuring the quality of their services. There is no requirement for accreditation or re-accreditation, although some hospitals or hospital departments are accredited.

A five-year developmental period (2013–17) is under way for quality-based financing of RHAs, based on performance and improvement on a set of indicators—29 indicators in 2014, increased to 33 indicators in 2015—of which patient experiences constitute about 30 percent of the reporting. Quality-based financing constitutes only about 0.5 percent of the total of the RHAs' budgets.

The Norwegian Institute of Public Health uses the Norwegian Prescription Database to produce annual reports on prescribing trends, giving national health authorities a statistical base for planning and monitoring the prescribing and use of drugs. Personal information held by the registry is anonymized.

What is being done to reduce disparities?

Eliminating socioeconomic inequalities in health is a priority of the Directorate for Health. A national strategy for addressing inequalities in health and health care includes various ways of increasing knowledge and awareness (Ministry of Health and Care Services 2007). There have been some initiatives for children, including vaccination programs, kindergarten and education; initiatives for people with disabilities to be included in the workplace; price and tax policies; initiatives for care integration; general information campaigns regarding smoking cessation, alcohol and diets; and specific initiatives for populations at risk.

There is increasing focus on immigrants' health and underutilization of health care. Research on pregnancy has been informative, as there are significantly more complications for newborns and mothers among immigrants than among Norwegians (Ahlberg and Vangen, 2005). The need for adequate information to be provided in immigrants' native languages has been emphasized.

Health outcomes vary geographically, not only because of differences in the prevalence of diseases but also as a result of variations in the availability and quality of health care. Recruitment of health personnel, notably doctors and specialized nurses, is more difficult in rural areas.

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What is being done to promote delivery system integration and care coordination?

Care coordination has been pointed out as a weakness in the health care system. The coordination reform of 2012 put more emphasis on municipalities' responsibility for 24-hour and post-discharge care, including individual treatment plans for patients with chronic diseases, but not for hospital treatment. Hospitals and municipalities must establish formal agreements on the care of patients with complex needs (Ministry of Health and Care Services 2009 and 2011). The number of integrated primary care practices is experiencing moderate growth, with GPs establishing common practices with physiotherapists and specialists in orthopedics, gynecology, ophthalmology, dentistry, and pediatrics.

For hospitals, incentives for care coordination are provided by mandatory agreements with municipalities. Financing is still fragmented between the hospitals (state-funded) and primary care (municipality-funded), but the municipalities pay substantial fines per day to hospitals if they are not able to accommodate patients ready for discharge.

What is the status of electronic health records?

A national strategy for health information technology (HIT) is the responsibility of the Directorate for Health, with implementation by a departmental steering committee. Every resident is allotted a unique personal identification number, which is used in primary care and for hospitals' medical records. Secure messaging is not a part of that system, but several GPs use such messaging systems, for instance to request prescriptions. Some GP and specialist outpatient offices have electronic booking, while most hospitals do not. All patients have the right to see or get a copy of their complete record, including doctors' notes, but there is not yet an electronic solution for doing so. An ongoing project on patient access currently gives 2.3 million inhabitants access to their core medical record, also allowing for correction of personal information.

The National Health Network is charged with providing efficient and secure electronic exchange of patient information between all relevant parties within the health and social services sector. It provides secure telecommunication for GPs, hospitals, nursing homes, pharmacists, dentists, and others.

HIT in primary care is fragmented, and some areas of service lack resources and equipment for its implementation. Still, virtually all GPs use electronic patient records and transmit prescriptions electronically to pharmacies. HIT is also used for referrals, communication with laboratories and radiology services, and sick leave. Most GPs receive electronic discharge letters from hospitals. Where after-hours emergency care is organized within the same patient record network, patient histories remain available and primary care providers are able to access information regarding emergency visits. All hospitals use electronic records.

The lack of structured electronic records in primary and secondary care precludes automatic data extraction; hence, there is still insufficient data for quality improvement at local and national levels.

How are costs contained?

Central government sets an overall health budget annually, and municipalities and RHAs are responsible for maintaining their budgets. The drug pricing scheme aims to encourage use of generic drugs. Cost-effectiveness is a criterion to get on the "blue list" of drugs eligible for reimbursement, and there is a defined maximum price for drugs, linked to reference prices set at the average of the three lowest market prices for the drug in a defined group of Scandinavian and Western European countries. The Drug Procurement Cooperation (LIS) has been effective in negotiating drug purchases and delivery jointly for the four RHAs.

Costs are contained through GP gatekeeping for specialized services. There is very little competition regarding pricing within the health services. A minute proportion of specialized care is offered to the private sector by RHAs and contracted through tenders, for which price is one of several criteria.

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The National System for the Introduction of New Health Technologies, established in 2014, bases its decisions on whether to approve new, costly drugs or treatment mainly on Health Technology Assessments, which address cost-effectiveness.

Norway has a low number of hospital beds (four per 1,000 inhabitants in 2012) compared with the OECD-Europe mean of five (OECD, 2014). The low number is part of a policy to drive services toward outpatient and daycare settings, and to make municipalities accountable for patients not needing specialized hospital care. There is an ongoing debate about overdiagnosing and use of procedures that are not evidence-based. Clinical guidelines and a published atlas of variation in frequency of some daytime surgical procedures (www.helseatlas.no) are the only measures taken to date to reduce "low value" care. Although the Council on Priorities in Health Care has debated, for instance, levels of end-of-life care and use of intensive care beds, no focused initiatives have resulted from the debates.

What major innovations and reforms have been introduced?

Municipality cofinancing of hospital care was abolished in 2015, as it was concluded that it did not have the intended effect of keeping patients out of the hospital.

Availability of single occupancy for patients in nursing homes for those preferring it has been a goal for many years. The realization that the goal had not been met led the government to introduce reduced payments by patients for occupancy in double rooms as a financial incentive (or penalty) for the municipalities effective from January 2015. No plan is in place for evaluation of the effect.

A new Agency for Hospital Construction (Sykehusbygg HF) was established in November 2014. Owned by the RHAs, the agency will serve as a national center of competence for hospital planning and construction for all hospital trusts. There is no plan for evaluation.

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The Singaporean Health Care System, 2015

Chang Liu and William Haseltine
Duke-NUS Graduate Medical School and ACCESS Health International



What is the role of government?

The government of Singapore planned, built, and continues to develop and maintain the nation's public health care system. It also regulates both public and private health insurance in the country. The health care system is administered by the Ministry of Health, which has responsibility for assessing health needs and for planning and delivering services through networks of health and hospital facilities, day care centers, and nursing homes. The ministry manages, plans for, and maintains staffing throughout the system and is also responsible for financing policies and governance of the entire public health care system. Because Singapore is a very small nation-state, there is little regional- or local-level funding or regulation; the national government takes on full responsibility for the health system. Singapore offers universal health care coverage to citizens, with a financing system anchored in the twin philosophies of individual responsibility and affordable health care for all.

Who is covered and how is insurance financed?

Publicly financed health care: The Singapore health care system is funded directly by the national government through its Ministry of Health. The ministry's budget for fiscal year 2013 was SGD5.9 billion (USD6.7 billion), or 1.6 percent of GDP. The funds come from general revenue, and they are used for subsidies, campaigns to promote good health practices, manpower development and training, and infrastructure expenses. Most of the budget is devoted to subsidies for patients receiving medical care at public hospitals, polyclinics, community hospitals, and certain institutions providing intermediate and long-term care. Other budget allocations are for initiatives addressing obesity prevention, tobacco control, childhood preventive health services, chronic disease management, and public education (Ministry of Health, 2013).

Singapore offers its citizens universal health care coverage, funded through a combination of government subsidies, multilayered financing schemes, and private individual savings, all administered at the national level. The first tier of protection is provided by government subsidies of up to 80 percent of the total bill in public hospitals and primary care polyclinics. There are also subsidies of up to 80 percent in the government-funded intermediate and long-term care institutions. This is supported by a system of savings and insurance programs to help individuals and families pay for their care—known as the "3Ms," for the Medisave, MediShield, and Medifund programs. Together, these play a critical role in maintaining Singaporeans' health and welfare.

Medisave is a mandatory medical savings program that requires workers to contribute a percentage of their wages to a personal account, with a matching contribution from employers. Individual contributions to and withdrawals from the accounts are tax-exempt. Account funds are used, under strict guidelines, to pay for health services such as hospitalization, day surgery, and certain outpatient expenses, as well as health insurance for the account holder and family members.

MediShield is a low-cost catastrophic health insurance scheme to help policyholders meet medical expenses for major or prolonged illnesses that their Medisave balance would not be sufficient to cover. All permanent residents are automatically enrolled in the program; undocumented immigrants and visitors are not covered.

MediShield operates on a copayment and deductible system, with premiums payable by the insured through Medisave. A universal health insurance scheme will replace MediShield at the end of 2015 (see below).

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Medifund is the government endowment fund set up to aid the indigent. The fund covers Singapore citizens who have received treatment from a Medifund-approved institution and have difficulties paying their medical bills despite government subsidies, Medisave, and MediShield coverage.

Privately financed health care: According to the World Health Organization (2013), in 2010, private expenditure amounted to 69 percent of the nation's total expenditure on care, 10.1 percent coming from private prepaid plans.

Private insurance is available from a number of for-profit companies, usually in the form of Medisave-approved Integrated Shield Plans. These plans serve as a supplement to MediShield, providing, for example, additional benefits and coverage when a patient opts for Class A and Class B1 wards in public hospitals or private hospitalization. Individuals can use funds from their Medisave accounts to pay the premiums for Integrated Shield Plans.

Employers also may offer private insurance to their employees as a staff benefit. Typically, employer-sponsored insurance cover primary care and other outpatient visits, in addition to hospitalization.



What is covered?

Services: Subsidies are available for care provided by public hospitals and polyclinics, as well as by government-funded intermediate and long-term care providers. MediShield, the second of the "3Ms," provides low-cost insurance coverage for treatments in the subsidized wards of public hospitals and outpatient care for certain conditions, including kidney dialysis and cancer treatments. As a catastrophic insurance program, MediShield generally does not cover primary care, prescription drugs, preventive services, mental health care, dental care, or optometry. MediShield is operated by the Central Provident Fund Board.

Cost-sharing and out-of-pocket spending: The government of Singapore contributes to building and maintaining the system and subsidizing a portion of the cost of patient care, based on the individual's ability to pay. Copayments after subsidy can be covered by MediShield insurance or paid for through Medisave savings. For MediShield, an annual deductible against claims must be met before coverage can begin. Coinsurance for inpatient bills ranges from 20 percent to 10 percent as the bill increases. Therefore, after government subsidies, MediShield pays between 80 percent and 90 percent of the claimable amount that exceeds the deductible for selected outpatient treatment charges claimable under MediShield (e.g., kidney dialysis, chemotherapy for cancer, and erythropoietin for chronic kidney failure). Other outpatient services are fully paid from private funds or, in some cases, employer benefits. Deductibles do not apply to outpatient treatments. Instead, a 20 percent coinsurance is imposed. There is no annual cap on out-of-pocket spending.

The health care system requires individuals to be ultimately responsible for their own health and to share in the cost of the services they use. Consequently, patients approach their health care choices knowing that they will pay a portion of the bill. In the Singapore system, patients are responsible for copayments and deductibles that are often higher than in other nations. According to the World Health Organization (2013), private spending amounts to 69 percent of total health care expenditure, of which 88 percent is out-of-pocket, including costs that are covered and reimbursed by employer medical benefits.

Safety net: Medifund, the third of the Singapore system's "3Ms," is an endowment program funded by the government as a health care safety net. It was established in 1993, and its mission is to help the poor pay for their care. Money from the fund is disbursed each year to approved institutions, and a committee at each institution evaluates and approves financial assistance to patients. Government-funded providers (whether public or private institutions, or voluntary welfare organizations) are able to tap Medifund assistance for their patients.

Medifund generally covers necessary medical treatment, including drugs, services, and tests. Medical social workers are in place to assist patients with the application process required before aid is granted. The amount of aid granted is determined by the patient's and the family's income, the social circumstances of the patient,

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the medical condition, and treatment costs. More than 90 percent of patients whose applications are approved receive assistance amounting to 100 percent of the outstanding portion of subsidized bills that they are unable to pay.

The ElderCare Fund is another government-established endowment fund established by the government. The endowment, which stands at SGD3 billion (USD3.4 billion), provides grants to intermediate and long-term care facilities to subsidize the care of low- and middle-income patients (Ministry of Health, 2013).[1]

How is the delivery system organized and financed?

Primary care: Primary care is mostly administered by the 1,400 private clinics offering such care (Ministry of Health, 2013). In addition, there are 18 public, multi-doctor polyclinics that provide subsidized outpatient care, immunization, health screening, and pharmacy services, with some offering dental care as well. These clinics, however, generally serve lower-income populations; the bulk of primary care is delivered by private general practitioner clinics.

Patients can choose their primary care doctor, and registration is not required. Private primary care doctors make referrals but generally do not function as gatekeepers. They are usually paid on a fee-for-service basis.

The Singapore system is strengthening its ties to private general practitioner networks. The Community Health Assist Scheme was introduced in 2012 to provide portable subsidies to Singaporeans from lower- to middle-income households. The scheme subsidizes visits to a participating private clinic for acute conditions, specified chronic illnesses, specified dental procedures, and recommended health screening. There are about 720 participating medical clinics and about 460 dental clinics.

Outpatient specialist care: A number of centers focus on medical specialties, including cancer, oral care, cardiovascular disease, diseases of the nervous system, and skin diseases. The National Heart Centre, for example, offers a full range of treatment, from prevention to rehabilitation and is the national and regional referral center for any cardiovascular complications. Research, teaching, and training are also conducted there. Specialists who work in the public system are salaried; they may also see nonsubsidized patients.

Administrative mechanisms for paying primary care doctors and specialists: The government pays subsidies directly to provider institutions, reimbursing them for a portion of treatment costs. Patients receive the subsidy benefits for outpatient care in both public clinics and public hospitals; for emergency care at public hospitals; for intermediate- and long-term care at facilities managed by voluntary welfare organizations; and, through means-testing, for care in private nursing homes. Eligible lower- to middle-income patients may also receive subsidies for outpatient treatment for chronic or acute conditions, and also certain dental procedures, at private primary care providers.

After-hours care: Numerous public and private hospitals offer 24-hour emergency care. There are approximately 30 24-hour clinics throughout the country, and many other clinics have late-night hours; lists of those clinics are available online. There is also a 24-hour emergency hotline that can be used for contacting ambulances operated by the Singapore Civil Defence Force. A mobile 24-hour house-call medical service is also available. Information on patient visits is not sent routinely to primary care doctors.

Hospitals: General care is delivered at regional hospitals. General hospitals offer acute inpatient services and specialist outpatient services, and have 24-hour emergency departments. In 2010, there were more than 11,000 beds (public and private sector) in 30 hospitals (15 public and 15 private, including specialty centers, community hospitals, and chronic care hospitals). In that same year, there were 4 million outpatient visits at public hospitals, two-thirds of them subsidized (Affordable Excellence, 2013).[1]

[1] Please note that, throughout this profile, all figures in USD were converted from SGD at a rate of about SGD0.88 per USD, the purchasing power parity conversion rate for GDP in 2013 reported by the World Bank (2014) for Singapore.

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Public hospital funding is derived from a block budget. Part of the budget is based on Casemix, which classifies medical conditions based on diagnosis-related groups. Hospitals can reallocate savings from the block budget to develop other aspects of public health care services. The block budgets are reviewed every three to five years to ensure that subvention models keep up with changes in models of care and hospital operations. In addition to the block grants, government funds are available for manpower training and research.

Wards in Singapore's public hospitals are tiered in four main classes, according to level of amenities. Patients in the highest-class wards are treated as private patients and therefore not subsidized. Patients in the other classes receive varying subsidies depending on the choice of ward and means-testing levels.

The private sector provides about 20 percent of secondary and tertiary care services. Raffles Medical Group and Parkway Health are two of the main private hospital groups; they generally offer faster service and more amenities, and are also more involved in medical tourism, than public facilities do. The public sector has begun renting private hospitals' spare capacity to treat subsidized patients, as private hospitals currently have more beds available.

Mental health care: Health care and social service agencies involved in mental health care are guided by the National Mental Health Blueprint of 2007, and provide integrated services such as education and prevention, early detection, and treatment for at-risk individuals or people facing emotional difficulties. The blueprint laid the groundwork for a network of care and support systems that will enable integrated community living. The Institute of Mental Health is Singapore's only acute tertiary psychiatric hospital. It provides psychiatric, rehabilitative, and counseling services for children, adolescents, adults, and the elderly, as well as long-term care and forensic services. Patients with addictions can be treated in the Institute's National Addictions Management Services unit. General and specialized treatment services for eating, sleep, and addictions disorders, and for geriatric psychiatry, are also offered at a number of public hospitals.

To cope with projected increase in demand for mental health care and to improve accessibility, the National Mental Health Blueprint calls for more community-based mental health services, led mainly by tertiary facilities. Components of the program include multidisciplinary shared-care teams operating in service networks in the community; support for caregivers; community safety networks for people with dementia and depression and their caregivers; and general practitioner training and support for the care and management of people with mental illnesses. There are also community-based mental health programs targeting youth, adults, and the elderly. Most cases requiring residential care or a transition period, with close supervision provided by the Institute of Mental Health and by two voluntary welfare organizations (Singapore Association for Mental Health and Singapore Anglican Community Services).

Long-term care and social supports: Management of long-term care services for the elderly is provided by voluntary welfare organizations and private operators. Services are financed in a number of ways, including direct payment by individuals and families, direct government subsidy to patients through providers, and capital and recurrent funding for intermediate and long-term care providers to provide means-tested, subsidized care. ElderShield, a long-term care insurance program regulated by the government but run through designated private insurers, is also available. ElderShield makes monthly direct cash payouts to those who can no longer take care of themselves. These payouts are intended to be setting-neutral, so that families and seniors can choose the type of care that best suits their needs. Eligible care includes nursing home, facility-based, and home-based health care, including hospice care.

Financial support is available for informal and family caregivers. The Agency for Integrated Care administers the Caregivers Training Grant that provides an annual SGD200 (USD228) subsidy to attend approved training courses in caring for elderly or persons with disability. The grant is allocated per care recipient, not per caregiver. Care recipients must be Singaporeans or permanent residents age 65 or older or with disability. The Foreign Domestic Worker Grant, a monthly grant of SGD120 (USD137) for hiring a foreign domestic worker to care for the frail elderly or for an individual with at least moderate disability, is also available through the Agency for Integrated Care. Eligibility requires a maximum household monthly income of SGD2,600 (USD2,965) (Ministry of Health, 2013).

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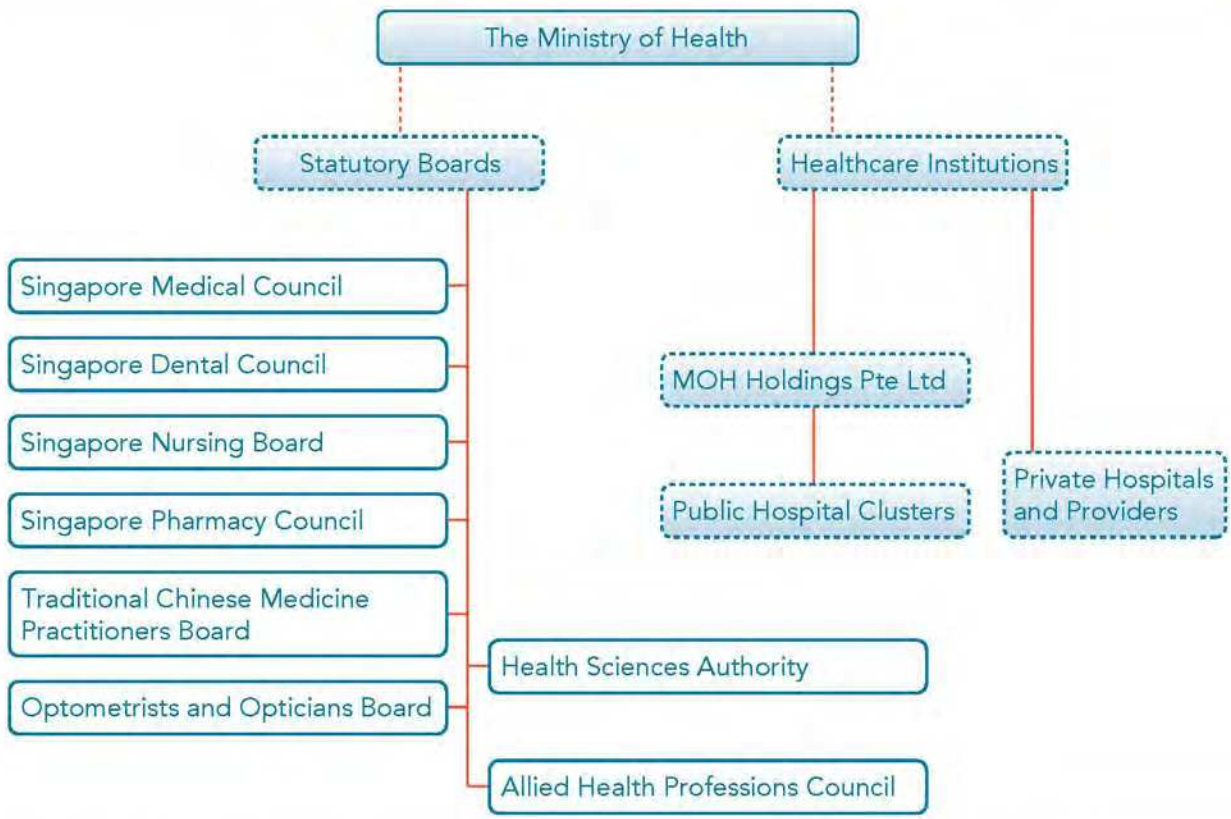
What are the key entities for health system governance?

Organization and planning: Singapore's Ministry of Health has overall responsibility for health care, setting policy direction and managing the public health care system. Its responsibilities include needs assessment, services planning, manpower planning, system governance and financing, provider fee-setting, cost control, and health information technology, with an overall goal of ensuring quality of care and responsiveness to Singaporeans' needs.

Regulation: The Ministry of Health regulates the health system through legislation and enforcement. Among the its core regulatory functions are licensing health care institutions under the Private Hospitals and Medical Clinics Act and conducting regular inspections and audits. Advertising is subject to monitoring and analysis to identify potential problems, which can lead to compliance audits and prosecutions in some cases. Marketing by licensed facilities is also regulated in order to safeguard the public against false or unsubstantiated claims and to prevent inducements to using nonessential services, such as aesthetic medicine.

Professional bodies, including the Singapore Medical Council, Singapore Dental Council, Singapore Nursing Board, and Singapore Pharmacy Board, regulate professionals through practice guidelines and codes of ethics and conduct. The Ministry of Health also engages these bodies to explain policy rationale and to garner support for various initiatives. The Health Sciences Authority regulates the manufacture, import, supply, presentation, and advertisement of health products, including conventional medicines, complementary medicines (traditional medicine and health supplements), cosmetic products, medical devices, tobacco products, and medicinal therapies for clinical trials. Its mission is to ensure that all these products meet internationally benchmarked standards of safety, quality, and efficacy. The insurance industry is regulated by the Monetary Authority of Singapore as part of its financial regulatory role.

Organization of the Health System in Singapore



Source: Adapted from Singapore Ministry of Health website.

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Public consultation: The government takes the views of patients and other stakeholders into account through various means, including the "Our Singapore Conversation" sessions and an online survey. Public consultation occurs before policies are enacted to ensure that public sentiment, concerns, and feedback are added to the discussion; that diverse views are heard and ideas are tested and refined; and that public understanding and support are cultivated to facilitate implementation. As an example, after public consultation, Medisave was expanded to include a variety of preventive and treatment services, such as mammograms and colonoscopies, treatment of some mental health disorders and chronic diseases, and palliative care.

What are the major strategies to ensure quality of care?

Singapore's Ministry of Health conducts an annual survey to gauge patient satisfaction and expectations regarding public health care institutions. The survey measures satisfaction with waiting times, facilities, and care coordination, among other health system attributes. Results of the 2012 survey show that 77 percent of respondents were satisfied, and that 78 percent of patients would "strongly recommend" or "likely recommend" institutions to others based on their own experience (Ministry of Health, 2013).

Public and private hospitals, clinics, laboratories, and nursing homes are required to submit applications to the health ministry for operating licenses. Physicians wishing to practice in Singapore must secure a position with a health care institution and register with the Singapore Medical Council, which maintains the official Register of Medical Practitioners. Physicians are required to fulfill continuing medical education requirements administered by the Medical Council. For institutions, prelicensing inspections are conducted to ensure standards.

Singapore uses a performance measurement and management process to help health care providers assess and benchmark their performance against peers. The National Health System Scorecard uses internationally established performance indicators to compare performance. The Public Acute Hospital Scorecard is used to measure institution-level performance. Its indicators cover clinical quality and patient perspectives. Similar scorecards for providers are being rolled out in primary care facilities and in community hospitals.

The scorecards define standards of service and key deliverables required of public health care institutions, and institutions are monitored to ensure compliance. The scorecards incorporate internationally accepted indicators and definitions where possible, such as the U.S. Center for Medicare and Medicaid Services' Joint Commission–aligned measures for acute myocardial infarction and stroke.

In 2008, Singapore introduced national standards for health care to set priorities for improvement efforts and alignment with planning initiatives. These standards focus on key areas of concern and are intended to promote a culture of continuous quality improvement. The national standards are implemented through the network of Healthcare Performance Offices, each chaired by a senior clinical leader who reports directly to the institution's chief executive officer or medical board chairman. Resulting quality improvement outputs can then be incorporated into the National Health System Scorecard and the Public Acute Hospital Scorecard for performance analysis and monitoring.

What is being done to reduce disparities?

Community Health Assist Scheme: The Community Health Assist Scheme subsidizes treatment for lower- and middle-income Singaporeans at private primary care sites. The subsidies cover acute conditions, 15 chronic conditions, and a range of dental procedures. Subsidies are also available for recommended screenings for obesity, diabetes, hypertension, lipid disorders, colorectal cancer, and cervical cancer.

Revised Central Provident Fund contribution rates: The Central Provident Fund is the umbrella account under which Singaporeans save for retirement, housing costs, and medical care (through the "3Ms"). There have been periodic increases in both employee and employer matching contribution rates in recent years, with another increase in the employer contribution rate to Medisave slated for January 2015. These increases are

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intended to encourage low-wage workers to save more for their retirement and medical needs and to have better access to care.

What is being done to promote delivery system integration and care coordination?

Singapore's Agency for Integrated Care was created in 2009 to bring about a patient-focused integration of primary and intermediate- and long-term care. The agency, which operates at the patient, provider, and system levels, works to encourage health care providers to coordinate their efforts on behalf of the patient. The agency also advises patients and families about appropriate health care services and helps them navigate the system. A primary example of the issues it addresses is follow-up treatment for chronic-disease patients discharged from the hospital. Another major initiative seeks to expand and improve health care capabilities at the community level. To achieve better integration of all care services, all six public hospital clusters in Singapore are undergoing a systemwide transformation to a regional health care system model. Hospitals will work in close partnership with other providers in their region, such as community hospitals, nursing homes, general practitioners, and home care providers.

Another significant role for the agency is to ensure integration of health and social care services for elderly and disabled populations. The agency coordinates and facilitates the placement of sick elderly people with nursing homes, community providers, day rehabilitation centers, and long-term care facilities, and manages referrals to home care services. The agency also actively helps the elderly and people with disability apply for available financial assistance.

What is the status of electronic health records?

Singapore is building a sophisticated national electronic health record system. The system collects, reports, and analyzes information to aid in formulating policy, monitoring implementation, and sharing patient records. The long-term goal is to allow medical professionals to access clinical data on patient treatment and safety. System capabilities include: a master index that matches patient records from a variety of sources and includes a unique identifier as well as other patient identity information; a summary care record for each patient that offers an overview of recent medical activity; access to overviews of specific events, such as hospital admissions; and access to health data in Singapore's registries for immunization, medical alerts, and allergies.

When fully developed, the system will allow data to be accessed and viewed in appropriate formats by medical professionals, patients, and researchers. Data sources will include the electronic medical record systems of public hospitals and polyclinics. There are plans to enable patients to view and possibly contribute to their personal health records.

How are costs contained?

Singapore spends just 4.7 percent of its GDP on health care (World Bank Health Data, 2014). Cost is controlled in a number of ways, perhaps foremost by the manner in which the government both fosters and controls competition—intervening when the market fails to keep costs down. Public and private hospitals exist side by side, with the public sector having the advantage of patient incentives and subsidies. Because it regulates prices for public hospital services and regulates the number of public hospitals and beds, the government is able to shape the marketplace. Within this environment, the private sector must be careful not to price itself out of the market.

At the same time, the government sets subsidy and cost-recovery targets for each hospital ward class, thereby indirectly keeping public sector hospitals from producing excess profits. Hospitals are also given annual budgets for patient subsidies, so they know in advance the levels of reimbursement they will receive for patient care. Within their budgets, hospitals are required to break even.

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To keep demand for services in check, the government possesses numerous tools, including copayments, deductibles, and restrictions on the use of Medisave and MediShield for consultations, treatments, and procedures. These controls discourage unnecessary doctor visits, tests, and treatments, resulting in more careful use of health system resources.

Price transparency: Another factor in controlling costs is price and outcome transparency. On its website, the Ministry of Health makes available hospital bills for common illnesses, treatments, and ward classes. Patients can look up costs for specific surgeries and tests, the number of cases treated in each hospital, and more. Data for public sector hospitals are complete; since private hospitals supply data voluntarily, the information may not offer the same level of detail. Armed with pricing information, consumers are able to shop better for the services they require.

Pooling of funds and purchasing: The Group Purchasing Office consolidates drug purchases at the national level. One goal of this system is to keep drug prices affordable by containing the costs of pharmaceutical-related expenditure. The Group Purchasing Office also purchases medical supplies, equipment, and IT services for the health care system.

What major innovations and reforms have been introduced?

Government spending: Since 2012, Singapore has been conducting a major review of the health care financing framework. In the 2012 health care budget, the Minister of Finance announced the government would increase its annual share of expenditure on health care from SGD4 billion (USD4.6 billion) to SGD8 billion (USD9.1 billion) over four years (Ministry of Health, 2012). The contribution by the government will soon rise from one-third to approximately 40 percent of the total, with the prospect of future increases.

Outpatient subsidies: To maintain affordability of health care, subsidies to lower- and middle-income patients at Specialised Outpatient Clinics in public hospitals were increased starting in September 2014. Subsidies for standard drugs will also be increased these patients beginning in January 2015. Increases are means-tested.

Medisave: Medisave use has been expanded gradually to cover chronic conditions and health screening and vaccinations for selected groups. In early 2015, Medisave will also cover outpatient scans needed for diagnosis and treatment.

MediShield Life: Changes to MediShield are being implemented to address the growing need for chronic disease care and long-term care. Coverage has become universal and compulsory, and now includes individuals with preexisting conditions. Previously ending at age 90, coverage is now for life. The lifetime cap on benefits has been removed, and the annual limit increased to SGD100,000 (USD114,000). Another recent change provides better protection from large hospital bills by reducing coinsurance payments below 10 percent, for the portion of the bill exceeding SGD5,000 (USD5,702) (Ministry of Health, 2014).

Medifund: In 2013, the government added SGD1 billion (USD1.1 billion) to Medifund's capital fund, which now totals SGD4 billion (USD4.6 billion). This increase will support the implementation of Medifund Junior, which will target assistance to needy children. It also allows for the extension of Medifund coverage in 2013 to primary care, dental services, prenatal care, and delivery. In the same year, annual assistance increased by almost 30 percent, to SGD130 million (USD148 million) (Ministry of Health, 2013).

Community Health Assist Scheme: Previously set at 40 years, the minimum age qualification for the program was removed in 2014. The household income ceiling for eligibility increased from SGD1,500 (USD1,711) to SGD1,800 (USD2,053) per capita per month. More chronic diseases were added, and subsidies for recommended health screening were introduced. These enhancements have enabled more lower- and middle income Singaporeans to benefit from the portable subsidies available at more than 1,000 medical and dental clinics (Ministry of Health, 2014).

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The Swedish Health Care System, 2015

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What is the role of government?

All three levels of Swedish government are involved in the health care system. At the national level, the Ministry of Health and Social Affairs is responsible for overall health and health care policy, working in concert with eight national government agencies. At the regional level, 12 county councils and nine regional bodies (regions) are responsible for financing and delivering health services to their citizens. At the local level, 290 municipalities are responsible care of the elderly and the disabled. The local and regional authorities are represented by the Swedish Association of Local Authorities and Regions (SALAR).

Three basic principles apply to all health care in Sweden:

1. *Human dignity:* All human beings have an equal entitlement to dignity and have the same rights regardless of their status in the community.
2. *Need and solidarity*: Those in greatest need take precedence in being treated.
3. *Cost-effectiveness:* When a choice has to be made, there should be a reasonable balance between the costs and the benefits of health care, measuring cost in relationship to improved health and quality of life.

Who is covered and how is insurance financed?

Publicly financed health care: Health expenditures represented 11 percent of GDP in 2013. About 84 percent of this spending was publicly financed, with county councils' expenditures amounting to 57 percent, municipalities' to 25 percent, and the central government's to almost 2 percent (Statistics Sweden, 2015a). The county councils and the municipalities levy proportional income taxes on their populations to help cover health care services. In 2013, 68 percent of county councils' total revenues came from local taxes and 18 percent from subsidies and national government grants financed by national income taxes and indirect taxes (SALAR, 2014). General government grants are designed to reallocate some resources among municipalities and county councils. Targeted government grants finance specific initiatives, such as reducing waiting times. In 2013, about 90 percent of county councils' total spending was on health care (SALAR, 2014).

Coverage is universal and automatic. The 1982 Health and Medical Services Act states that the health system must cover all legal residents. Emergency coverage is provided to all patients from European Union / European Economic Area countries and to patients from nine other countries with which Sweden has bilateral agreements. Asylum-seeking and undocumented children have the right to health care services, as do children who are permanent residents. Adult asylum seekers have the right to receive care that cannot be deferred (e.g., maternity care). Undocumented adults have the right to receive nonsubsidized immediate care.

Private health insurance: Private health insurance, in the form of supplementary coverage, accounts for less than 1 percent of expenditures. Associated mainly with occupational health services, it is purchased primarily to ensure quick access to an ambulatory care specialist and to avoid waiting lists for elective treatment. Insurers are for-profit. In 2015, 614,000 individuals had private insurance, accounting for roughly 10 percent of all employed individuals aged 15 to 74 years (Swedish Insurance Federation, 2015).

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What is covered?

Services: There is no defined benefits package. The publicly financed health system covers public health and preventive services; primary care; inpatient and outpatient specialized care; emergency care; inpatient and outpatient prescription drugs; mental health care; rehabilitation services; disability support services; patient transport support services; home care and long-term care, including nursing home care and hospice care; dental care and optometry for children and young people; and, with limited subsidies, adult dental care. As the responsibility for organizing and financing health care rests with the county councils and municipalities, services vary throughout the country.

Cost-sharing and out-of-pocket spending: In 2013, about 16 percent of all expenditures on health were private, and of these 93 percent were out-of-pocket (Statistics Sweden, 2015a). The majority of out-of-pocket spending is for drugs.

The county councils set copayment rates per health care visit and per bed-day, leading to variation across the country. Providers cannot charge above the scheduled fee. The table below shows fee ranges for 2014.

Service	Fee Range (2014)	
	Swedish Kroner	U.S. Dollars
Primary care physician visit	100–300	11–34
Hospital physician consultation	200–350	22–39
Hospitalization per day	80–100	9–11

Source: SALAR, 2015.

Nationally, annual out-of-pocket payments for health care visits are capped at SEK1,100 (USD123) per individual. In all county councils, people under age 18—and in most county councils, people under 20—are exempt from user charges for visits.

Dental care: Dental and pharmaceutical benefits are determined at the national level. People under 20 have free access to all dental care. People 20 or older receive a fixed annual subsidy of SEK150–SEK300 (USD17–USD34), depending on age, for preventive dental care. For other dental services, within a 12-month period patients 20 or older pay the full cost of services up to SEK3,000 (USD335), 50 percent of the cost for services between SEK3,000 and SEK15,000 (USD1,676), and 15 percent of costs above SEK15,000. There is no cap on user charges for dental care.

Prescription drugs: Individuals pay the full cost of prescribed medications up to SEK1,100 (USD123) annually, after which the subsidy gradually increases to 100 percent. The annual ceiling for out-of-pocket payments for prescriptions is SEK2,200 (USD246) for adults. A separate annual out-of-pocket maximum of SEK2,200 applies collectively to all children belonging to the same family. For certain prescription drugs not on the National Drug Benefits Scheme and not subject to reimbursement, patients must pay the full price.

Safety net: Because the Swedish health care system is designed to be socially responsible and equity-driven, all social groups are entitled to the same benefits. The ceilings on out-of-pocket spending apply to everyone, and the overall cap on user charges is not adjusted for income. Children, adolescents, pregnant women, and the elderly are generally targeted groups, exempted from user charges or granted subsidies for certain services such as maternity care or vaccination programs.

* Please note that, throughout this profile, all figures in USD were converted from SEK at a rate of about SEK8.95 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Sweden.

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How is the delivery system organized and financed?

The health system is highly integrated. An important policy initiative driving structural changes since the 1990s has been the shifting of inpatient care to outpatient and primary care, and the concentration of highly specialized care in academic medical centers. All provider fees are set by county councils, leading to variation across the country. Public and private physicians (including hospital specialists), nurses, and other categories of health care staff at all levels of care are predominantly salaried employees. The average monthly salary for a physician with a specialist degree (including specialists in general medicine) was SEK73,000 (USD8,157) in 2014 (Statistics Sweden, 2015b). There is no regulation prohibiting physicians (including specialists) and other staff who work in public hospitals or primary care practices from also seeing private patients outside the public hospital or primary care practice. Employers of health care professionals, however, may establish such rules for their employees.

Primary care: Primary care accounts for about 20 percent of all expenditures on health, and about 16 percent of all physicians work in this setting (Swedish Medical Association, 2013, 2014). Primary care has no formal gatekeeping function. Team-based primary care, with general practitioners, nurses, midwives, physiotherapists, psychologists, and gynecologists, is the main form of practice. There are, on average, four general practitioners in a primary care practice. General practitioners or district nurses are usually the first point of contact for patients. District nurses employed by municipalities also participate in home care and regularly make home visits, especially to the elderly; they have limited prescribing authority.

People may register with any public or private provider accredited by the local county council, with most individuals registering with a practice instead of a physician. Registration is not required to visit a practice. There are more than 1,100 primary care practices, of which 40 percent are privately owned. Providers (public and private) are paid a combination of fixed payment for their registered individuals (about 80% of total capitated payment), fee-for-service (17%–18%), and performance-related payment (2%–3%) for achieving quality targets in such areas as patient satisfaction, enrollment in national registers, compliance with guidelines based on evidence-based medicine, and recommendations from county council drug formulary committees.

Outpatient specialist care: Outpatient specialist care is provided at university and county council hospitals and in private clinics. Patients have a choice of specialist. Public and private providers are paid through the same fixed, prospective, per-case payments (based on diagnosis-related groups), complemented by price or volume ceilings and quality components.

Administrative mechanisms for direct patient payments to providers: Patients normally pay the provider fee up front for primary care and other outpatient visits. In most cases, it is also possible for patients to pay later.

After-hours care: Primary care providers are required to provide after-hours care in accordance with the conditions for accreditation in each county council. Practices in proximity to each other (normally three to five practices) collaborate on after-hours arrangements. Through their websites and phone services, providers advise their registered patients where to go for care. Staff providing after-hours primary care services normally include general practitioners as well as nurses. There is no special arrangement for provider payment, and the same copayments apply as those during regular hours (see above, "Cost-sharing and out-of-pocket spending"). Information regarding after-hours patient visits is routinely sent to the practice where the patient is registered.

In addition, seven university hospitals and about 50 county council hospitals provide full emergency services 24 hours a day.

All county councils and regional bodies provide information on how and where to seek care through their websites and a national phone line, with medical staff available all day to give treatment advice. Moreover, all county councils and their regional counterparts collaborate to provide online information about pharmaceuticals, medical conditions, and pathways for seeking care. A similar private collaboration exists as well.

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Hospitals: There are seven university hospitals, and about 70 hospitals at the county council level. Six of them are private, and three of those are not-for-profit. The rest are public. Counties are grouped into six health care regions to facilitate cooperation and to maintain a high level of advanced medical care. Highly specialized care, often requiring the most advanced technical equipment, is concentrated in university hospitals to achieve higher quality and greater efficiency and to create opportunities for development and research. Acute care hospitals (seven university hospitals and two-thirds of the 70 county council hospitals) provide full emergency services. Global budgets or a mix of global budgets, diagnosis-related groups, and performance-based methods are used to reimburse hospitals. Two-thirds or more of total payment is usually in the form of budgets, and about 30 percent is based on DRGs. Performance-based payment related to attainment of quality targets constitutes less than 5 percent of total payment. The payments are traditionally based on historical (full) costs.

Mental health care: Mental health care is an integrated part of the health care system and is subject to the same legislation and user fees as other health care services. People with minor mental health problems are usually attended to in primary care settings, either by a general practitioner or by a psychologist or psychotherapist; patients with severe mental health problems are referred to specialized psychiatric care in hospitals. Specialized inpatient and outpatient psychiatric care, include that related to substance use disorders, is available to adults, children, and adolescents.

Long-term care and social supports: Responsibility for the financing and organization of long-term care for the elderly and for the support of people with disabilities lies with the municipalities, but the county councils are responsible for those patients' routine health care. Older adults and disabled people incur a separate maximum copayment for services commissioned by the municipalities (SEK1,780 [USD199] per month in 2015). The Social Services Act specifies that older adults have the right to receive public services and assistance at all later stages of life, e.g., home care aids, home help, and meal deliveries. Also included is end-of-life care, either in the individual's home or in a nursing home or hospice. The Health and Medical Services Act and the Social Services Act regulate how the county councils and the municipalities manage palliative care. The organization and quality of palliative care vary widely both between and within county councils. Palliative care units are located in hospitals and hospices. An alternative to palliative care in a hospital or hospice is advanced palliative home care.

There are both public and private nursing homes and home care providers. About 14 percent of all nursing home and home care was privately provided in 2012 (Statistics Sweden, 2015a), although the percentage varies significantly among municipalities. Payment to private providers is usually contract-based, following a public tendering process. Eligibility for nursing home care is based on need, which is determined collaboratively by the client and staff from the municipality; often a relative participates as well. There is a national policy to promote home assistance and home care over institutionalized care, and that policy entitles older people to live in their homes for as long as possible. Municipalities can also reimburse informal caregivers either directly ("relative-care benefits") or by employing the informal caregiver ("relative-care employment").



What are the key entities for health system governance?

The Health and Medical Services Act specifies that responsibility for ensuring that everyone living in Sweden has access to quality health care lies with the county councils and municipalities. The county councils are responsible for the funding and provision of health services, while the municipalities are responsible for meeting the care and housing needs of older adults and people with disabilities. In primary care, there is competition among providers (public and private) to register patients, although they cannot compete through pricing, since the county councils set fees.

County councils control the establishment of new private practices by regulating conditions for accreditation and payment. Those conditions pertain primarily to opening hours and to the minimum number of clinical competencies at the practice. The right to establish a practice and be publicly reimbursed applies to all public and private providers fulfilling the conditions for accreditation.

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The central government, through the Ministry of Health and Social Affairs, is responsible for overall health care policies. There are eight government agencies directly involved in the areas of medical care and public health.

The National Board of Health and Welfare supervises all health care personnel, disseminates information, develops norms and standards for medical care, and, through data collection and analysis, ensures that those norms and standards are met. The agency is the licensing authority for health care staff. (Health care personnel are not required to reapply for their license.) The National Board of Health and Welfare also maintains health data registries and official statistics.

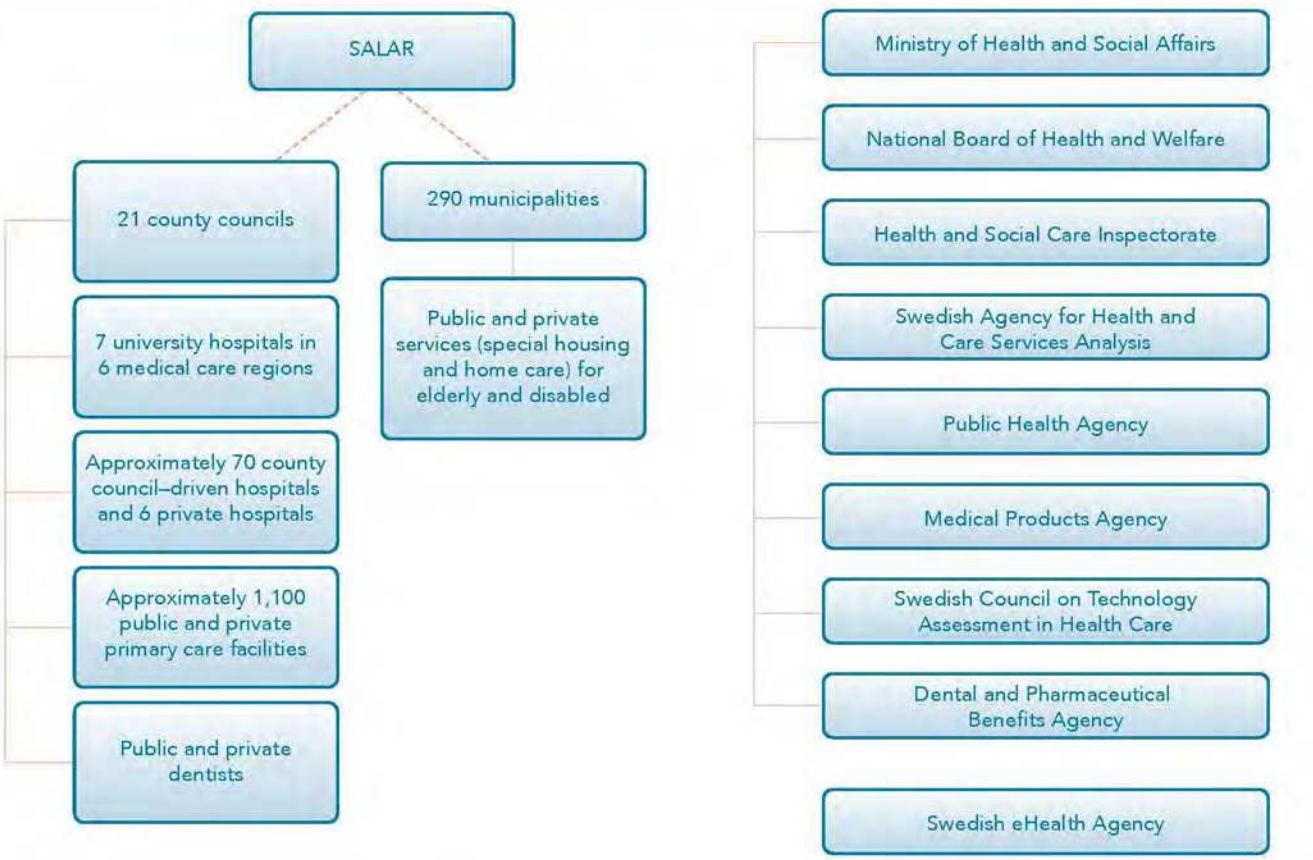
The Swedish eHealth Agency, established in 2014, focuses on promoting public involvement and providing support for professionals and decision-makers. The agency stores and transfers electronic prescriptions issued in Sweden and is responsible for transferring electronic prescriptions abroad. The agency is also responsible for Sweden's national drug statistics and for statistics on pharmaceutical sales.

The Health and Social Care Inspectorate is responsible for supervising health care, social services, and activities concerning support and services for persons with certain functional impairments. It is also responsible for issuing permits in those areas.

The Swedish Agency for Health and Care Services Analysis analyzes and evaluates health policy, as well as the availability of health care information to citizens and patients. The results of such analyses are published.

The Public Health Agency provides the national government, government agencies, municipalities, and county councils with new knowledge, based on scientific evidence, in the area of infectious disease control and public health, including health technology assessment. The Swedish Council on Technology Assessment in Health

Organization of the Health System in Sweden



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Care, which promotes use of cost-effective health care technologies, has a mandate to review and evaluate new treatments from medical, economic, ethical, and social points of view. Information from the council's reviews is disseminated to central and local government officials and medical staff to provide basic data for decision-making purposes.

The principal agency for assessing pharmaceuticals is the Dental and Pharmaceutical Benefits Agency. Since 2002, it has had a mandate to decide whether particular drugs should be included in the National Drug Benefit Scheme; prescription drugs are priced in part on the basis of their value. The agency's mandate also includes dental care. The Medical Products Agency, meanwhile, is the Swedish national authority responsible for the regulation and surveillance of the development, manufacture, and sale of drugs and other medicinal products.

What are the major strategies to ensure quality of care?

County councils are responsible for accrediting health care providers and following up on conditions for accreditation. These activities include assessing whether quality targets—those associated with a pay-for-performance scheme or tied to requirements for continued accreditation—have been achieved. Providers are evaluated based on information from patient registries and national quality registries, surveys related to patient satisfaction, and clinical audits.

Concern for patient safety has increased during the past decade, and patient safety indicators are compared regionally (see below). Eight priority target areas for preventing adverse events have been specified: health care–associated urinary tract infections; central line infections; surgical site infections; falls and fall injuries; pressure ulcers; malnutrition; medication errors in health care transitions; and drug-related problems (SALAR, 2011).

The National Board of Health and Social Welfare, together with the National Institute for Public Health and the Dental and Pharmaceutical Benefits Agency, conducts systematic reviews of evidence and develops guidance for establishing priorities in support of disease management programs developed at the county council level. International guidelines and specialists are also central to the development of these local programs. There is a tendency to develop regional guidelines to inform the setting of priorities in order to avoid unnecessary variation in clinical practice. For example, the National Cancer Strategy was established in 2009, and six Regional Cancer Centers (RCCs) were formed in 2011. The RCCs' role is to contribute to more equitable, safe, and effective cancer care through regional and national collaboration.

The 90 or so national quality registries are used for monitoring and evaluating quality among providers and for assessing treatment options and clinical practice. Registries contain individualized data on diagnosis, treatment, and treatment outcomes. They are monitored annually by an executive committee, funded by the central government and by county councils, and managed by specialist organizations.

Since 2006, the government has published annual performance comparisons and rankings of the county councils' health care services, using data from the national quality registers, the National Health Care Barometer Survey, the National Waiting Time Survey, and the National Patient Surveys. The 2012 publication included 169 indicators, organized into various categories such as prevention, patient satisfaction, waiting times, trust, access, surgical treatment, and drug treatment. Some 50 indicators are shown also for hospitals, but without rankings. Statistics on patient experiences and waiting times in primary care are also made available through the Internet (www.skl.se) to help guide people in their choice of provider.

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What is being done to reduce disparities?

The 1982 Health and Medical Services Act emphasizes equal access to services on the basis of need, and a vision of equal health for all. International comparisons indicate that health disparities are relatively low in Sweden. The National Board of Health and Welfare and the Public Health Agency compile and disseminate comparative information about indicators on public health. Approaches to reducing disparities include programs to support behavioral changes, and the targeting of outpatient services to vulnerable groups in order to prevent diseases at an early stage. To prevent providers from avoiding patients with extensive needs, most county councils allocate funds to primary care providers based on a formula that takes into account both overall illness (based on diagnoses) and registered individuals' socioeconomic conditions.

What is being done to promote delivery system integration and care coordination?

The division of responsibilities between county councils (for medical treatment) and municipalities (for nursing and rehabilitation) requires coordination. Efforts to improve collaboration and develop more integrated services include the development of national action plans supported by targeted government grants. In 2005, Sweden introduced a "guarantee" to improve access to care and to ensure the equality of that access across the country. The guarantee is based on the "0–7–90–90 rule": instant contact (zero delay) with the health system for advice; seeing a general practitioner within seven days; seeing a specialist within 90 days; and waiting no more than 90 days to receive treatment after being diagnosed. For county councils to be eligible for the grant targeted at accessibility, 70 percent of all patients must receive care within the stipulated time frames. At the county council level, providers are eligible for grants linked partly to the fulfillment of goals related to coordination and collaboration in care provided to the elderly with multiple diagnoses.

What is the status of electronic health records?

Generally, both the quality of IT systems and their level of use are high in hospitals and in primary care; more than 90 percent of primary care providers used electronic patient records for diagnostic data in 2009 (Health Consumer Powerhouse, 2009). Nearly all Swedish prescriptions are e-prescriptions. Patients increasingly have access to their electronic medical record for the purposes of scheduling appointments or viewing their personal health data, but there is variation in this regard between county councils. The Swedish eHealth Agency (*eHälsomyndigheten*) was formed in 2014 to strengthen the national e-health infrastructure. Its activities focus on promoting public involvement and providing support for professionals and decision makers (see governance section, above).

How are costs contained?

County councils and municipalities are required by law to set and balance annual budgets for their activities. For prescription drugs, the central government and the county councils form agreements, lasting a period of years, on the levels of subsidy paid by the government to the councils. The Dental and Pharmaceutical Benefits Agency also employs value-based pricing for prescription drugs, determining reimbursement based on an assessment of health needs and cost-effectiveness. In some county councils, there are also local models for value-based pricing for specialized care such as knee replacements.

Because county councils and municipalities own or finance most health care providers, they are able to undertake a variety of cost-control measures. For example, contracts between county councils and private specialists are usually based on a tendering process in which costs constitute one variable used to evaluate different providers. The financing of health services through global budgets, volume caps, capitation formulas, and contracts, as well as salary-based pay for staff, also contributes to cost control, as providers retain responsibility for meeting costs with funds received through those prospective payment mechanisms. In several counties, providers are also financially responsible for prescription costs.

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What major innovations and reforms have been introduced?

Important policy areas that have been under scrutiny at both the local and the national level during the last two years include the quality and equity of care, coordination of care, and patients' rights.

Studies following Sweden's 2010 market reform in primary care show that objectives related to accessibility have been achieved. Its effects on quality, equity, and efficiency, however, are unclear. Accurate reporting and monitoring to measure these criteria remain important challenges in Swedish primary care and are a concern for policymakers.

In the area of specialized care, there have been recent efforts to foster greater equity. The government has committed to providing SEK500 million (USD55.87 million) per year from 2015 to 2018 to reduce waiting times in cancer care and to reduce regional disparities. This effort is to be built on work previously undertaken within the framework of the National Cancer Strategy and the six Regional Cancer Centers (RCCs). In addition, a commission on equitable health, established in 2015, is to submit a report (due by the end of May 2017) containing proposals for reducing health inequalities in society.

To improve continuity and coordination of care, in 2014 the government launched a four-year national initiative for people with chronic diseases. Its three areas of focus are patient-centered care, evidence-based care, and prevention and early detection of disease.

In 2015, a new law addressing patients' rights went into effect, with the purpose of strengthening the rights of patients and enhancing patient integrity, influence, and shared decision-making. The law clarifies and expands providers' responsibility in conveying information to their patients, patients' right to a second opinion, and patients' choice of provider in outpatient specialist care throughout the country. The government has commissioned the Swedish Agency for Health and Care Services Analysis to monitor and follow up on implementation of the new law until 2017.

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The Swiss Health Care System, 2015

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What is the role of government?

Duties and responsibilities in the Swiss health care system are divided among the federal, cantonal, and communal levels of government. The system can be considered highly decentralized, as the cantons are given a critical role. The 26 cantons (including six half-cantons) are responsible for licensing providers, coordinating hospital services, and subsidizing institutions and organizations. Cantons are like U.S. states in that they are sovereign in all matters, including health care, that are not specifically designated as the responsibility of the Swiss Confederation by the federal constitution. Each canton and half-canton has its own constitution articulating a comprehensive body of legislation.

Who is covered and how is insurance financed?

Publicly financed health insurance: There are three streams of public funding:

1. Direct financing for health care providers through tax-financed budgets for the Swiss Confederation, cantons, and municipalities. The largest portion of this spending is given as cantonal subsidies to hospitals providing inpatient acute care.

2. Mandatory statutory health insurance (SHI) premiums.

3. Social insurance contributions from health-related coverage of accident insurance, old-age insurance, disability insurance, and military insurance.

All government expenditures are financed by general taxation. In 2013, direct spending by government accounted for 20.2 percent of total health expenditures (CHF69.2 billion, or USD50.5 billion), while income-based SHI subsidies accounted for an additional 5.8 percent.[†] Including SHI premiums (30.9% of total health expenditure, excluding statutory subsidies), other social insurance schemes (6.5%), and old age and disability benefits (4.4%), publicly financed health care accounted for 67.9 percent of all spending (SFOS, 2015a).

Mandatory SHI coverage is universal. Residents are legally required to purchase SHI within three months of arrival in Switzerland, which then applies retroactively to the arrival date. Policies typically apply to the individual, are not sponsored by employers, and must be purchased separately for dependents.

There are virtually no uninsured residents. Temporary nonresident visitors pay for care up front, and must claim expenses from any coverage they may hold in their home country. Missing SHI for undocumented immigrants remains an unsolved problem acknowledged by the Swiss Federal Council (SFC), the highest governing and executive authority.

SHI is offered by competing nonprofit insurers supervised by the Federal Office of Public Health (FOPH), which sets floors for premiums offered to cover past, current, and estimated future costs for insured individuals in a given region. Cantonal average annual premiums in 2015 for adults range from CHF3,836 (USD2,800) to CHF6,398 (USD4,670) (Appenzell Innerrhoden; Basel-Stadt). Funds are redistributed among insurers by a central fund, in accordance with a risk equalization scheme adjusted for canton, age, gender, and hospital or nursing home stays of more than three days in the previous year.

[†] Please note that, throughout this profile, all figures in USD were converted from CHF at a rate of about CHF1.37 per USD, the purchasing power parity conversion rate for GDP in 2014 reported by OECD (2015) for Switzerland.

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Insurers offer premiums for defined geographical "premium regions" limited to three per canton. Within every region, the criteria for variation in premiums are limited to age group, level of deductible, and alternative insurance plans (so-called managed care plans with the main characteristic of giving up free choice of first medical contact), but variations in premiums among insurers can be significant. In 2013, 60.6 percent of residents opted for basic coverage with a health maintenance organization, an independent practice association, or a fee-for-service plan with gatekeeping provisions (FOPH, 2014).

Private health insurance: Private expenditure accounted for 32.1 percent of total health expenditure in 2013 (SFOS, 2015a), which is high by comparison with other OECD countries (OECD, 2011). There is complementary voluntary health insurance (VHI, 7.3% of total expenditure) for services not covered in the basic basket of SHI, and supplementary coverage for free choice of hospital doctor or for a higher level of hospital accommodation. No data are available on the number of people covered.

VHI is regulated by the Swiss Financial Market Supervisory Authority. Insurers can vary benefit baskets and premiums and can refuse applicants based on medical history. Service prices are usually negotiated directly between insurers and providers. Unlike statutory insurers, voluntary insurers are for-profit; an insurer will often have a nonprofit branch offering SHI and a for-profit branch offering VHI. It is illegal for voluntary insurers to base voluntary insurance subscription decisions on health information obtained via basic health coverage, but this rule is not easily enforced.

What is covered?



Services: The Federal Department of Home Affairs (FDHA) defines the SHI benefits basket by evaluating whether services are effective, appropriate, and cost-effective. It is supported in this task by the FOPH and by Swissmedic, the agency for authorization and supervision of therapeutic products.

SHI covers most general practitioner (GP) and specialist services, as well as an extensive list of pharmaceuticals, medical devices, home health care (called Spitex), physiotherapy (if prescribed), and some preventive measures, including the costs of selected vaccinations, selected general health examinations, and screenings for early detection of disease among certain risk groups (e.g., one mammogram per year for women with a family history of breast cancer).

Hospital services are also covered by SHI, but highly subsidized by cantons (see below). Care for mental illness is covered if provided by certified physicians. The services of nonmedical professionals (e.g., psychotherapy by psychologists) are covered only if prescribed by a qualified medical doctor and provided in his or her practice. SHI covers only "medically necessary" services in long-term care. The FOPH and Swiss Conference of Cantonal Health Ministers aim to eliminate the gaps in financing of hospice care. Dental care is largely excluded from SHI, as are glasses and contact lenses for adults (unless medically necessary), but these are covered for children.

Cost-sharing and out-of-pocket spending: Insurers are required to offer minimum annual deductibles of CHF300 (about USD219) for adults under SHI, although insured persons may opt for a higher deductible (up to CHF2,500 [USD1,825]) and a lower premium. In 2013, 23.5 percent of all insured persons opted for the standard CHF300 deductible; the other 76.5 percent chose a higher deductible or another model with a gatekeeping element.

Insured persons pay 10 percent coinsurance above deductibles for all services (including GP consultations), but is capped at CHF700 (USD511) for adults and at CHF350 (USD255) for minors (under age 19) in a given year. There is also a 20 percent charge for brand-name drugs with a generic alternative. For treatment in acute-care hospitals, there is a CHF15 (USD11) copayment per inpatient day. Cost-sharing in SHI and VHI accounted for 5.6 percent and 0.1 percent of total health expenditure in 2013.

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Moreover, out-of-pocket payments for services not covered by insurance (and in addition to cost-sharing) accounted for 18.1 percent of total health expenditure. Most of these direct out-of-pocket payments were spent on dentistry and long-term care. Providers are not allowed to charge prices higher than SHI will reimburse.

Safety net: Maternity care and some preventive services are fully covered and thus exempt from deductibles, coinsurance, and copayments. Minors do not pay deductibles or copayments for inpatient care. Federal government and cantons provide income-based subsidies to individuals or households to cover SHI premiums; income thresholds vary widely by canton (Swiss Conference of Cantonal Health Ministers, 2015a). Overall, 28 percent of residents (in 2013) benefit from individual premium subsidies. Municipalities or cantons cover the health insurance expenses of social assistance beneficiaries and recipients of supplementary old age and disability benefits.

How is the delivery system organized and financed?

Primary care: As registering with a GP is not required, people not enrolled in managed care plans generally have free choice among self-employed GPs. In 2014, 38.5 percent of doctors in the outpatient sector were classified as GPs. Apart from scale-of-charge measures (see below), there are no specific financial incentives for GPs to take care of chronically ill patients, and no concrete reforming efforts are underway to engage GPs in "bundled payments" for chronic patients (e.g., diabetics). Primary (and specialist) care tends to be physician-centered, with nurses and other health professionals playing a relatively small role. In 2014, 57.2 percent of physicians were in solo practice (Hostettler and Kraft, 2015).

Apart from some managed care plans in which physician groups are paid through capitation, ambulatory physicians (including GPs and specialists) are paid according to a national fee-for-service scale (TARMED). While billing above the fee schedule is not permitted, TARMED offers some incentives for less resource-intensive forms of care. These incentives, however, are criticized by GPs as insufficient to render attractive such services as home visits, after-hours care, and coordinating and communicating with chronically ill patients. In response, the SFC decided to slightly increase remuneration for consultations in primary care as of October 2014, while remuneration for some more technical services (such as computer tomography) has been slightly reduced. The median income of primary care doctors was CHF197,500 (USD144,151) in 2009 (Künzi and Strub, 2012).

Outpatient specialist care: In the outpatient sector, 61.5 percent of doctors were classified as specialists in 2014 (Hostettler and Kraft, 2015). Residents have free access (without referral) to specialists unless enrolled in a gatekeeping managed care plan. Specialist practices tend to be concentrated in urban areas and within proximity of acute-care hospitals. Mostly self-employed specialists can schedule appointments in public hospitals with both SHI and private patients.

Administrative mechanisms for direct patient payments to providers: SHI allows different methods of payment among insurers, patients, and providers. Providers can invoice the patient, who pays up front and claims reimbursement from the insurer, or the patient can forward the invoice to the insurer for payment. Alternatively, providers can directly bill the insurer, who makes payment and bills any balance to the patient.

After-hours care: Cantons are responsible for after-hours care. They delegate those services (fees set by TARMED) to cantonal doctors' associations, which organize care networks in collaboration with their affiliated doctors. The networks can include ambulance and rescue services, hospital emergency services, and walk-in clinics and telephone advice lines run or contracted by insurers. There is no institutionalized exchange of information between these services and GPs' offices (as people are not required to register).

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Hospitals: About 70 percent of the 293 acute inpatient hospitals (in 2013) are public or publicly subsidized private hospitals (SFOS, 2015b). For services covered by SHI and billed through a national diagnosis-related group (DRG) payment system, hospitals[2] receive around half (45%–55%) of their funding from insurers (Swiss Conference of Cantonal Health Ministers, 2015b). The other half is covered by cantons and communes, or, in case of additional services, by private health insurance. There are no arrangements for bundled payments to include entire episodes of care are not used.

Cantons are responsible for hospital planning and funding, and are legally bound to coordinate plans with other cantons. The introduction in 2012 of free movement of patients between cantons under the DRG system has reduced cantonal fragmentation. Remuneration mechanisms depend on insurance contracts; as a consequence, fee-for-service is still possible for inpatient services not covered under SHI. Hospital-based physicians are normally paid a salary, and public-hospital physicians can receive extra payments for seeing privately insured patients.

Mental health care: Psychiatric practices are generally private, and psychiatric clinics and hospital departments are a mix of public, private with state subsidies, and fully private. There is also a wide range of socio-psychiatric facilities and daycare institutions that are mainly state-run and -funded.

Psychiatric hospitals or clinics normally provide a full range of medical services like psychiatric diagnostics and treatment, psychotherapy, pharmaceutical treatment, and forensic services. Often, the socio-psychiatric facilities and daycare institutions offer the same medical services as the clinics, but normally treat patients with less acute illnesses or symptoms. The main field of activity of psychiatric practices is psychotherapy that can be supplemented by pharmaceutical treatment. The provision of psychiatric care is not systematically integrated into primary care. Prices for outpatient psychiatric services are calculated using TARMED, while psychiatric inpatient care prices are usually calculated as a daily rate.

Long-term care and social supports: Services are provided for inpatient care (in nursing homes and institutions for disabled and chronically ill persons) and for outpatient care through Spitex. In some cases admission is possible only through a hospital or by approval from an admission authority. Palliative care provided in hospitals, in nursing homes, in hospices, or at home is not regulated separately in SHI, so coverage of services is similar to acute services in the respective provider setting. There is no provision of individual or personal budgets for patients to organize their own services.

Inpatient long-term somatic and mental services are covered by SHI, but are highly subsidized by cantons. For services in nursing homes and institutions for disabled and chronically ill persons, SHI pays a fixed contribution to cover care-related inpatient long-term care costs; the patient pays at most 20 percent of care-related costs that are not covered, and the remaining care-related costs are financed by the canton or the commune. Long-term inpatient care costs totaled CHF12.0 billion (USD8.8 billion) in 2013, representing 17.4 percent of total health expenditures. Around one-third of these costs (32.0%) were paid by private households, one-quarter (24.1%) by old age and disability benefits, 18.4 percent by SHI and other social insurances, and the rest by government subsidies (25.5%). Of the 1,580 nursing homes (as of 2013), 29.6 percent are state-operated and -funded, 29.6 percent are privately operated with public subsidies, and 40.8 percent are exclusively private (SFOS, 2015c).

Almost half of total Spitex expenditure of CHF2.0 billion (USD1.4 billion), as of 2013 (SFOS, 2015d), is financed by government subsidies (47.5%). SHI and the other social insurances covering the cost of medically necessary health care at home made up roughly one-third (30.0%). The rest (22.6%), devoted mainly to support and household services, was paid out-of-pocket, by old age and disability benefits, by VHI, and by other private funds (SFOS, 2015a). There is no legal basis for financial support for informal help or family caregivers. Most Spitex organizations are subsidized nonprofit organizations (85% of personnel), while the remaining 15 percent are nonsubsidized for-profit organizations (SFOS, 2015d).

2 This includes private hospitals that receive public subsidies if the cantonal governments have need of their services to guarantee a sufficient supply for Sweden.

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What are the key entities for health system governance?

Since health care is largely decentralized, the key entities for health system governance exist mainly at the cantonal level. Each of the 26 cantons has its own elected minister of public health. Supported by their respective cantonal offices of public health, ministers are responsible for licensing providers, coordinating hospital services, subsidizing institutions, and promoting health through disease prevention. Their common political body, the Swiss Conference of the Cantonal Ministers of Public Health, plays an important coordinating role. At the cantonal and the national level, market pressure, i.e., from competition, is felt most by hospitals and by health insurers (OECD, 2011).

The main national player is the FOPH, which, among other tasks, supervises the legal application of mandatory SHI, authorizes insurance premiums offered by statutory insurers, and governs statutory coverage (including health technology assessment) and the prices of pharmaceuticals. Other cost-control measures are shared with cantonal and communal governments. The FDHA legally defines the SHI benefits basket. Professional self-regulation has been the traditional approach to quality improvement.

Prices for outpatient services are set in the fee-for-service scale TARMED, which defines the relative cost weights of all services covered by SHI on the national level and is authorized by the Swiss Federal Council. TARMED values can vary among cantons and service groups (physicians, outpatient hospital services) as negotiated annually between the health insurers' associations and cantonal provider associations, or are set by cantonal government if the parties cannot agree. For inpatient care, the Swiss national DRG system has been in use since 2012. The nonprofit corporation SwissDRG AG is responsible for defining, developing, and adapting the national system of relative cost weights per case.

In addition to the responsibilities of the FOPH and cantonal governments, Health Promotion Switzerland, a nonprofit organization financed by SHI, is legally charged with disease prevention and health promotion programs and provides public information on health. A national ombudsman for health insurance and the Association of Swiss Patients engage in patient advocacy.

What are the major strategies to ensure quality of care?

Providers must be licensed in order to practice medicine, and are required to meet educational and regulatory standards; continuing medical education for doctors is compulsory. Local quality initiatives, often at the provider level, include the development of clinical pathways, medical peer groups, and consensus guidelines. However, there are no explicit financial incentives for providers to meet quality targets.

The Quality Strategy, approved by the SFC at 2009, takes a broad conceptual approach with different fields of action, including the implementation of a national pilot program by the Swiss Foundation for Patient Security on medication safety in acute-care hospitals, a pilot program to reduce hospital infections, and the publication of quality indicators for acute-care hospitals. Quality-control mechanisms usually do not involve information from registries or patient surveys. Registries are organized by private initiatives or cantons, such as the cantonal cancer registries.

At the end of 2013, the SFC mandated a task force led by the cantons and the Swiss Confederation (the Dialogue on National Health Policy) to work out a national strategy for the prevention of noncommunicable diseases (NCDs) by 2016. The strategy aims to improve the health competence of the population and promote healthy living conditions. The National Health Report (Obsan, 2015) discusses the growing number of case management programs for chronic illnesses.

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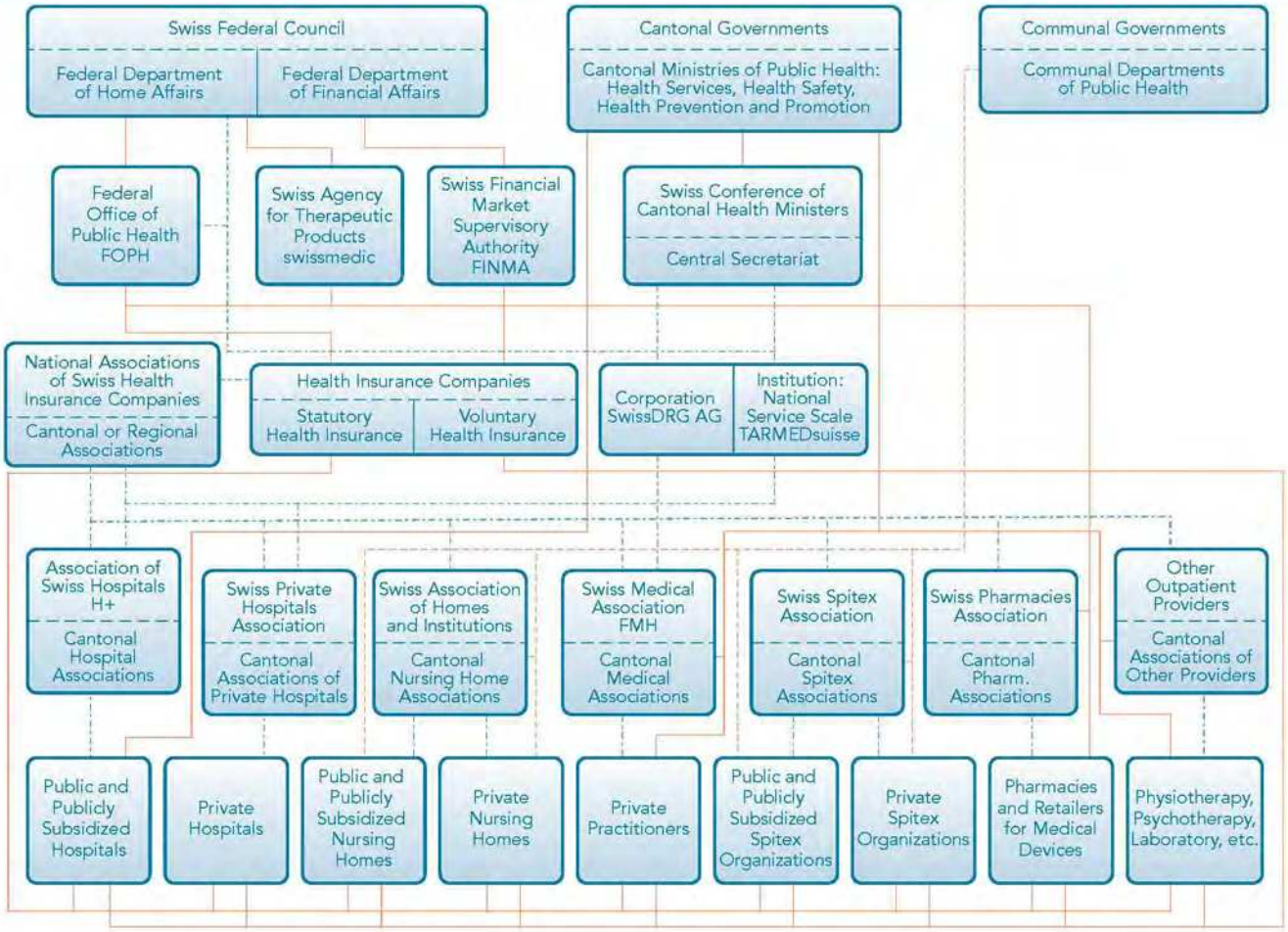
Organization of the Health System in Switzerland



Source: P. Camenzind, Swiss Health Observatory, 2015.

What is being done to reduce disparities?

There are several reasons why health disparities have not attracted as much political and professional interest at the national level as elsewhere: Health inequalities are not considered to be very significant in comparison to other OECD countries; it is difficult to obtain detailed statistical information about the epidemiology of health outcomes; and health inequalities are seen more as the responsibility of cantons, making them less visible at the national level.

The Swiss Federal Council's national Health2020 agenda (FDHA, 2013) includes the explicit objective of improving the health opportunities of the most vulnerable population groups, such as children and the young, those on low incomes or with a poor educational background, the elderly, and immigrants. The aim is to prevent vulnerable population groups from being unable to make appropriate use of necessary health care services. Health and health access variations are measured and reported publicly by the Swiss Health Survey (SFOS, 2014) every five years.

What is being done to promote delivery system integration and care coordination?

Care coordination is an issue, particularly in light of a projected lack of providers in the future and the need to improve efficiency to increase capacity. The task force Dialogue on National Health Policy discusses existing and

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new approaches to care. The national Health2020 agenda includes a comprehensive projection of the priorities of health care policy until the year 2020. The agenda also addresses care coordination, stating that integrated health care models need to be supported in all areas. The FOPH works on concrete measures to confront these challenges.

Strategies and networks tackling emerging areas of importance, like palliative care, dementia, and mental health, have been created to improve coordination. They start on a conceptual level, aiming at the practical level to encourage different types of health professionals to work together. A growing number of such programs are in the works, as shown in the National Health Report (Obsan, 2015), but pooled funding streams do not exist yet. It is also worth noting the efforts in the area of e-health (see below), which should considerably improve coordination as well.



What is the status of electronic health records?

A national e-health service called eHealth Suisse (an administrative unit of the FOPH) is coordinated by the federal and cantonal governments and has three sets of responsibilities. First, all providers in Switzerland should be able to collect and store information on their patients' treatment electronically. Second, health-related websites and online services will be required to undergo quality certification and a national health website will be constructed. Third, necessary legal changes will be made to realize these measures.

A key element of eHealth Suisse is the SHI subscription card, which encodes a personal identification number and all necessary administrative data. If allowed by the insured person, information about allergies, illnesses, and medication can be recorded on the card. The insured person also decides who is allowed access to this information (all, selected, or no providers). GP e-health is still at an early stage (Vilpert, 2012), and there are ongoing discussions about incentives for physicians to adopt new technologies.

Hospitals are generally more advanced; some have merged their internal clinical systems in recent years and hold interdisciplinary patient files. However, the extent of this integration varies greatly among hospitals and among cantons, despite efforts by eHealth Suisse to convince providers of the benefits of electronic health records for medical practice. An interoperable national patient record is not a priority for eHealth Suisse, since the principles of decentralization, privacy, and data protection are regarded as very important.



How are costs contained?

Switzerland's health care costs are among the highest in the world. "Regulated competition" (Enthoven, 1993) among nonprofit health insurers and among service providers is aimed at containing costs and guaranteeing high-quality health care, and establishing solidarity among the insured. While most of its objectives are considered successfully achieved, academic analyses (OECD, 2011) and public perception have been critical of competition's ability to control health care costs. A global budget, however, has never been regarded as a possible remedy for this problem. Failures are ascribed largely to inadequate risk equalization, the dual funding of hospitals, and pressure on insurers to contract with all certified providers (OECD, 2011). The costs of providing mandatory benefits in the health system could be reduced by up to 20 percent (FDHA, 2013).

An overview of possible cost-reducing measures—in coordination of care, compensating systems, and highly specialized medicine—is part of the Health2020 agenda. The agenda outlines a need for increasing flat-rate remuneration mechanisms and revising existing fee schedules to limit incentives for service providers. Also mentioned is the need for greater concentration in sites of highly specialized medicine to eliminate inefficiency and duplication in infrastructure systems and to increase the quality of health care provision. SwissDRG AG was introduced to contain hospital costs. Inpatient capacity is subject to cantonal planning requirements, and there is a "necessity clause for outpatient providers." See also the section on cost-sharing for patient cost-sharing mechanisms.

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To control pharmaceutical costs, coverage decisions on all new medicines are subject to evaluation of their effectiveness (by Swissmedic) and cost (by the FOPH). Efforts are being made to reassess more frequently the prices of older drugs. Depending on national market volume, generics must be sold for 20 to 50 percent less than the original brand. In addition to the aforementioned 20 percent coinsurance for brand-name drugs, pharmacists are paid flat amounts for prescriptions, so they have no financial incentive to dispense more expensive drugs.

What major innovations and reforms have been introduced?

As discussed throughout this profile, the Health2020 agenda outlines important national topics, objectives, and measures for improving quality of life, promoting equal opportunity and self-responsibility, ensuring and enhancing quality of care, and creating more transparency, better governance, and more coordination. In concrete terms, the SFC realized the following nine priorities in 2014 (SFC, 2015):

- Adoption of the message (i.e., official explaining text of SFC) concerning the federal law of cancer registries (implementation date of law: not before 2018;
- Submission for public consultation of the preliminary draft of a federal law concerning a national health quality institute in SHI (new proposal made by the Swiss Federal Council, with open date for implementation);
- Submission for public consultation of a partial revision of the federal law on SHI concerning better control of the outpatient sector, more control of health care cost, and better assurance of health care quality (implementation date of law: mid-2016);
- Submission for public consultation of the preliminary draft of a federal law concerning non-ionizing radiation and sound waves (implementation date of law: open);
- Submission for public consultation of the preliminary draft of a federal law concerning tobacco products (implementation date of law: open);
- Adoption of regulation on the adjustments of tariff structures in SHI (regulation introduced: October 2014);
- Adoption of the results of a public consultation on the federal law concerning health professionals (implementation date of law: open);
- Adoption of the results of a report on the current state of and need for action to support caring relatives;
- Recognition of the results of the new constitutional article concerning primary health care and plans to enact it (implementation date: open).

The Swiss Health Observatory (Obsan) is currently creating an indicator system to evaluate the effects of all measures proposed by the Health2020 agenda.

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What is the role of government?

The Affordable Care Act (ACA), enacted in 2010, established "shared responsibility" between the government, employers, and individuals for ensuring that all Americans have access to affordable and good-quality health insurance. However, health coverage remains fragmented, with numerous private and public sources as well as wide gaps in insured rates across the U.S. population. The Centers for Medicare and Medicaid Services (CMS) administers Medicare, a federal program for adults age 65 and older and people with disabilities, and works in partnership with state governments to administer both Medicaid and the Children's Health Insurance Program, a conglomeration of federal–state programs for certain low-income populations.

Private insurance is regulated mostly at the state level. In 2014, state- and federally administered health insurance marketplaces were established to provide additional access to private insurance coverage, with income-based premium subsidies for low- and middle-income people. In addition, states were given the option of participating in a federally subsidized expansion of Medicaid eligibility.

Who is covered and how is insurance financed?

In 2014, about 66 percent of U.S. residents received health insurance coverage from private voluntary health insurance (VHI): 55.4 percent received employer-provided insurance, and 14.6 percent acquired coverage directly.[1] Public programs covered roughly 36.5 percent of residents: Medicare covered 16 percent, Medicaid 19.5 percent, and military health care insurance 4.5 percent (U.S. Census Bureau, 2014).

In 2014, 33 million individuals were uninsured, representing 10.4 percent of the population (U.S. Census Bureau, 2014). The implementation of the ACA's major coverage expansions in January 2014, however, has increased the share of the population with insurance. These reforms include: the requirement that most Americans procure health insurance; the opening of the health insurance marketplaces, or exchanges, which offer premium subsidies to lower- and middle-income individuals; and the expansion of Medicaid in many states, which increased coverage for low-income adults. According to one survey, the rate of uninsurance among working-age adults fell by 7 percentage points between March 2015 and September 2013 (Collins et al., 2015); another survey found that 17.6 million previously uninsured people have acquired health insurance coverage (ASPE, 2015a). It is projected that the ACA will reduce the number of uninsured by 24 million by 2018 (CBO, 2015).

Public programs provide coverage to various, often overlapping populations. In 2011, nearly 10 million Americans were eligible for both Medicare and Medicaid (the "dual eligibles") (Henry J. Kaiser Family Foundation, 2015a). The Children's Health Insurance Program (CHIP), which in some states is an extension of Medicaid and in others a separate program, covered more than 8.1 million children in low-income families in 2014 (Medicaid.gov, 2014).

Undocumented immigrants are generally ineligible for public coverage, and nearly two-thirds are uninsured. Hospitals that accept Medicare funds (which are the vast majority) must provide care to stabilize any patient with an emergency medical condition, and several states allow undocumented immigrants to qualify for emergency Medicaid coverage beyond "stabilization" care. Some state and local governments provide additional coverage, such as coverage for undocumented children or pregnant women.

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[1] Estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

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What is covered?

Services: The ACA requires all health plans offered in the individual insurance market and small-group market (for firms with 50 or fewer employees) to cover services in 10 essential health benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health services and substance use disorder treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care. Each state determines the range and extent of specific services covered under each category by selecting a benchmark plan that covers all 10 categories; most states choose one of the largest small-group plans as the benchmark. Specific covered services vary somewhat by state.

Private insurance plans sometimes use narrow networks of providers, with limited or no coverage if patients receive out-of-network care. Private coverage for dental care and optometry is also available—sometimes through separate policies—as is long-term care insurance. Private health insurance is required to cover certain preventive services (with no cost-sharing if provided in network).

Medicare provides coverage for hospitalization, physician services, and, through a voluntary supplementary program, prescription drug coverage. The program also has eliminated cost-sharing for a number of preventive services. Medicare offers a choice between "traditional" Medicare, which is open-network and pays predominately on a fee-for-service basis, and Medicare Advantage, under which the federal government pays a private insurer for a network-based plan. Medicare covers postacute care but not long-term care, while Medicaid offers more extensive long-term care coverage (see below). In addition, Medicaid covers a broad range of core services, including hospitalization and physician services, with certain optional benefits varying by state.

Cost-sharing and out-of-pocket spending: Cost-sharing provisions in private health insurance plans vary widely, with most requiring copayments for physician visits, hospital services, and prescription drugs. High-deductible health plans—those with a minimum annual deductible of $1,250 per individual or $2,500 per family—can be paired with tax-advantaged health savings accounts (i.e., deposited funds are not subject to federal income tax). The ACA includes cost-sharing subsidies for the purchase of plans through the insurance exchanges, with the largest subsidies aimed at people with incomes below 250 percent of the federal poverty level (FPL) (the FPL is $20,090 for a family of three, as of 2015) (ASPE, 2015b).

Medicare requires deductibles for hospital stays and ambulatory care and copayments for physician visits and other services, while Medicaid requires minimal cost-sharing. Most public and private insurers prohibit providers from balance billing—charging patients more than the copayment required by their insurance plan—if they have an agreement with the payer to accept their set or negotiated payment amounts. Out-of-pocket spending accounts for 12 percent of total health expenditures in the U.S. (OECD, 2015). The ACA caps cost-sharing for most private insurance plans at $6,600 for individuals and $13,200 for families per year in 2015 (Healthcare.gov, 2015).

Safety nets: A variable and patchwork mix of organizations and programs deliver care for uninsured, low-income, and vulnerable patients in the United States, including public hospitals, local health departments, free clinics, Medicaid, and CHIP. Under the ACA, 30 states and the District of Columbia have expanded Medicaid coverage to cover individuals with incomes up to 138 percent of FPL (Commonwealth Fund, 2015), and premium and cost-sharing subsidies are now available to low- and middle-income individuals through the insurance exchanges (plan premium subsidies for incomes of 133%–400% of FPL; cost-sharing subsidies for incomes of 100%–250% of FPL). Hospitals that provide care to a high percentage of low-income and uninsured patients receive disproportionate share hospital (DSH) payments from Medicare and Medicaid to partially offset their uncompensated care; however, these payments are being substantially reduced as the ACA reduces the number of the uninsured. The federal government also funds community health centers, which provide a major source of primary care for underserved and uninsured populations. In addition, private providers are a significant source of charity and uncompensated care.

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How is the delivery system organized and financed?

Publicly financed health care: In 2013, public spending accounted for about 48 percent of total health care spending, although this figure is expected to increase post-ACA (OECD, 2015). Medicare is financed through a combination of payroll taxes, premiums, and federal general revenues. Medicaid is tax-funded and administered by the states, which operate the program within broad federal guidelines. States receive matching funds from the federal government for Medicaid at rates that vary based on their per-capita income—in 2014, federal matching ranged from 50 percent to 73 percent of states' Medicaid expenditures (ASPE, 2014). The expansion of Medicaid under the ACA is fully funded by the federal government through 2017, after which the government's funding share will be phased down to 90 percent by 2020. Federal premium subsidies on the exchanges are offered as tax credits.

Privately financed health care: In 2013, private health insurance spending accounted for about 33 percent of total health care spending (CMS, 2015a). Private insurers, which can be for-profit or nonprofit, are regulated by state insurance commissioners and subject to varying state (and federal) regulations. Private health insurance can be purchased by individuals but is usually funded by voluntary, tax-exempt premiums, the cost of which is shared by employers and workers on an employer-specific basis, sometimes varying by type of employee. The employer tax exemption is the government's third-largest health care expenditure (after Medicare and Medicaid), reducing tax revenues by $260 billion per year (NBER, 2014).

Some individuals are covered by both public and private health insurance. For example, many Medicare beneficiaries purchase private supplemental Medigap policies to cover additional services and cost-sharing. Private insurers, in general, pay providers at rates higher than those paid by public programs, particularly Medicaid. This disparity leads to wide variations in provider payment rates and revenues, which depend to a large extent on payer mix and market power.

Medicare's payment rates are typically determined according to a fee schedule, with various adjustments based on cost of living and other local and provider characteristics. Medicaid rates vary by state. Private health insurers typically negotiate payment rates with providers.

Primary care: Primary care physicians account for roughly one-third of all U.S. doctors. The majority operate in small self- or group-owned practices with fewer than five full-time-equivalent physicians, although larger practices are becoming increasingly common. Practices—particularly large ones—often include nurses and other clinical staff, who are usually paid a salary by the practice. Patients generally have free choice of doctor, at least among in-network providers, and are usually not required to register with a primary care practice, depending on their insurance plan. Primary care doctors have no formal gatekeeping function, except within some managed care plans.

Physicians are paid through a combination of methods, including negotiated fees (private insurance), capitation (private insurance), and administratively set fees (public insurance). Physicians also can receive financial incentives, made available by some private insurers and public programs like Medicare, based on various quality and cost performance criteria. Insured patients are generally directly responsible for some portion of physician payment, and uninsured patients are nominally responsible for all or part of physicians' charges, although those charges can be reduced or waived.

Outpatient specialist care: Specialists can work in both private practice and hospitals. Some insurance plans (such as health maintenance organizations, or HMOs) require a referral by a primary care doctor to see a specialist, and limit patients' choice of specialist, while other plans (such as preferred provider organizations, or PPOs) allow patients broader and direct access. Access to specialists can be particularly difficult for Medicaid beneficiaries and the uninsured, as some specialists refuse to accept Medicaid patients owing to low reimbursement rates, and because safety-net programs for specialist care are limited. Like primary care physicians, specialists are paid through negotiated fees, capitation, and administratively set fees, and are typically not allowed to bill above the fee schedule for services offered in-network. Multispecialty and single-specialty groups are increasingly common. Specialists can see patients with either public or private insurance.

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Administrative mechanisms for paying primary care doctors and specialists: Copayments for doctor visits are typically paid at the time of service or are billed to the patient afterward. Some insurance plans and products (including health savings accounts) require patients to submit claims to receive reimbursement. Providers bill insurers by coding the services rendered; this process can be very time-consuming, as there are thousands of codes.

After-hours care: After-hours access to primary care is limited (39% of primary care doctors in 2015 reported having after-hours care arrangements) (Osborn et al., 2015), with such care often being provided by hospital emergency departments. As of 2007, there were between 12,000 and 20,000 urgent-care centers in the U.S. providing walk-in after-hours care. Most urgent-care centers are independently owned by physicians, while about 25 percent are owned by hospitals (Rice et al., 2013). Some insurance companies make after-hours telephone advice lines available.

Hospitals: Hospitals can be nonprofit (approximately 70% of beds nationally), for-profit (15% of beds), or public (15% of beds). Public hospitals can serve private patients. Hospitals are paid through a combination of methods, including per-service or per-diem charges, per-case payments, and bundled payment, in which case the hospital may be financially accountable for readmissions and services rendered by other providers. Some hospital-based physicians are salaried hospital employees, but most are paid on some form of fee-for-service basis—physician payment is not included in Medicare's diagnosis-related group (DRG) payments. Hospitalists are increasingly common and now present in a majority of hospitals.

Mental health care: Mental health care is provided by a mix of for-profit and nonprofit providers and professionals—including psychiatrists, psychologists, social workers, and nurses—and paid for through a variety of methods that vary by provider type and payer. Most insurance plans cover inpatient hospitalization, outpatient treatment, emergency care, and prescription drugs; other benefits may include case management and peer support services.

The Affordable Care Act aimed to improve access to mental health care by establishing it as an essential health benefit (see above), applying federal parity rules to ensure that coverage is comparable, and increasing access to health insurance more generally.

Long-term care and social supports: Long-term care is provided by a mix of for-profit and nonprofit providers, and paid for through a variety of methods that vary by provider type and payer. Medicaid, but not Medicare, offers the most extensive coverage of long-term care, although it varies from state to state (within federal eligibility and coverage requirements). Since Medicaid is a means-tested program, patients must often "spend down" their assets to qualify for long-term care assistance. However, hospice care is included as a Medicare benefit, as are skilled short-term nursing services and nursing home stays of up to 100 days. Long-term care insurance that offers comprehensive care is available but rare. Most certified nursing facilities are for-profit (69%), while 24 percent are nonprofit and 6 percent are government-owned (Henry J. Kaiser Family Foundation, 2015b). Caregiver support programs and personal health budgets—such as cash and counseling programs in Medicaid—are available in some states to support caregivers and recipients of home-based care. Some of these programs allow recipients to employ family members. However, most informal and family caregivers do not receive payment or benefits for their work.



What are the key entities for health system governance?

The Department of Health and Human Services (HHS) is the federal government's principal agency involved with health care services. Organizations that fall within HHS include the:

- Centers for Medicare and Medicaid Services:
- Centers for Disease Control and Prevention, which conducts research and programs to protect public health and safety;

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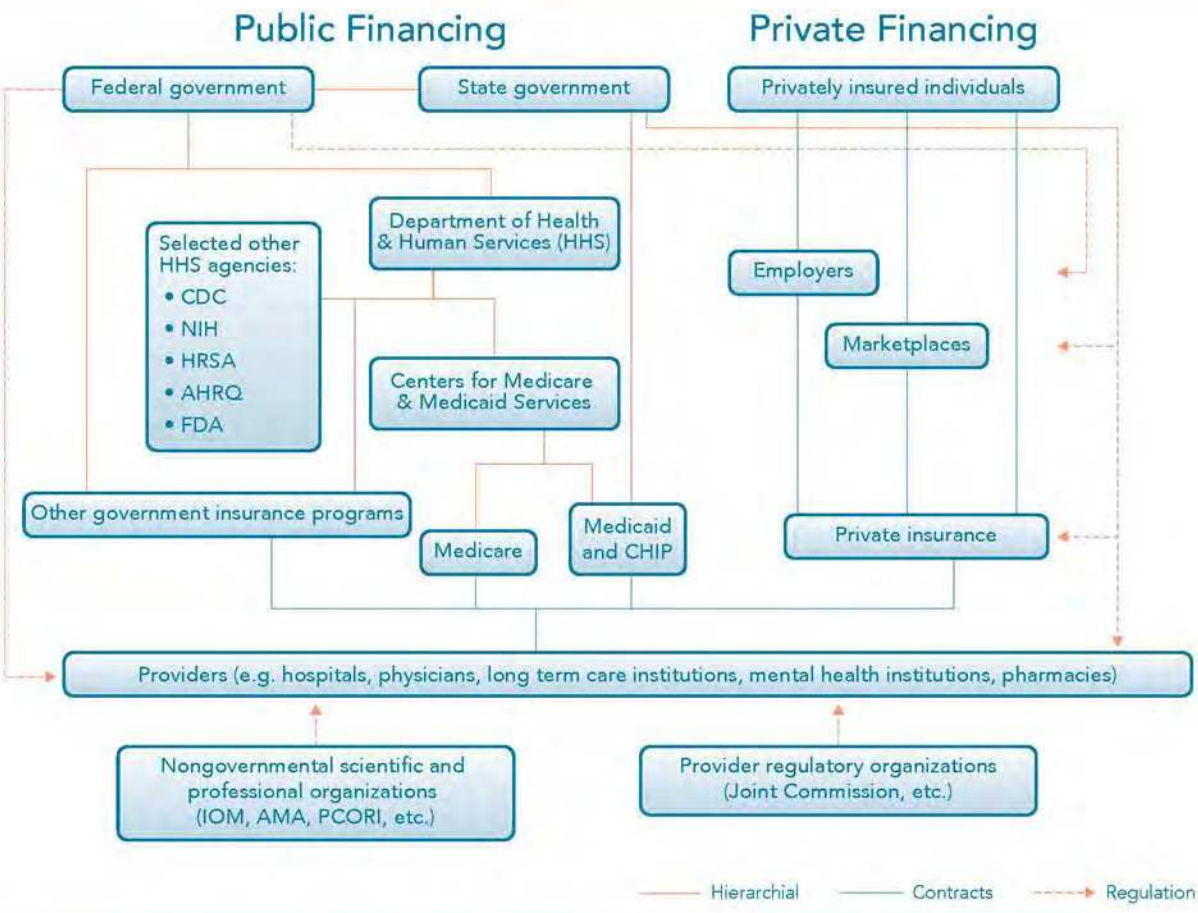
- National Institutes of Health, which is responsible for biomedical and health-related research;
- Health Resources and Services Administration, which supports efforts to improve health care access for people who are uninsured, isolated, or medically vulnerable;
- Agency for Healthcare Research and Quality, which conducts evidence-based research on practices, outcomes, effectiveness, clinical guidelines, safety, patient experience, health information technology, and health disparities;
- Food and Drug Administration, which is responsible for promoting public health through the regulation of food, tobacco products, pharmaceutical drugs, medical devices, and vaccines, among other products;
- Center for Medicare and Medicaid Innovation, an agency within CMS that was created by the Affordable Care Act to test and disseminate promising payment and service delivery models designed to reduce spending while preserving or improving quality; and
- Patient-Centered Outcomes Research Institute, also created by the ACA, which is tasked with setting national clinical comparative-effectiveness research priorities and managing research on a broad array of topics related to illness and injury.

Organization of the Health System in the United States



Source: Adapted from T. Rice, P. Rosenau, L. Y. Unruh et al., "United States of America: Health System Review," *Health Systems in Transition*, vol. 15, no. 3, 2013, p. 27.

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The Institute of Medicine (IOM), an independent nonprofit organization that works outside of government, acts as an adviser to policymakers and the private sector on improving the nation's health. Stakeholder associations (e.g., the American Medical Association) comment on and lobby for policies affecting the health system.

The independent, nonprofit Joint Commission accredits more than 20,000 health care organizations across the country, primarily hospitals, long-term care facilities, and laboratories, using criteria that include patient treatment, governance, culture, performance, and quality improvement. The National Committee for Quality Assurance, the primary accreditor of private health plans, is responsible for accrediting the plans participating in the newly created health insurance marketplaces. The nonprofit National Quality Forum builds consensus on national performance priorities and on standards for performance measurement and public reporting. The American Board of Medical Specialties and the American Board of Internal Medicine provide certification to physicians who meet specified standards of quality.

What are the major strategies to ensure quality of care?

In 2011, the Department of Health and Human Services released the National Quality Strategy, a component of the ACA that lays out national aims and priorities to guide local, state, and national quality improvement efforts, supported by an array of partnerships with public and private stakeholders. Current initiatives include efforts to reduce hospital-acquired infections and preventable readmissions (see below).

CMS has moved toward increased public reporting of provider performance data in an effort to promote improvement. One such initiative is Hospital Compare, a service that reports on measures of care processes, care outcomes, and patient experience at more than 4,000 hospitals. In additional, with support from the ACA and such groups as the Open Government Partnership, CMS is making Medicare data available to "qualified entities," such as health improvement organizations, which are beginning to release data on payments made by Medicare to individual physicians and amounts paid to physicians and hospitals by pharmaceutical and device companies. Release of such information is intended to both increase transparency and improve quality.

States have developed additional public reporting systems and measures, including some that address ambulatory care. Consumer-led groups, such as Consumers Union and the Leapfrog Group, also report on quality and safety.

Incentives to reduce avoidable hospital readmissions among Medicare patients were introduced in October 2012, by way of financial penalties. Since the program's initiation, 20-day readmission rates nationally have declined from 19 percent to less than 18 percent (Blumenthal et al., 2015). Incentives to reduce hospital-acquired conditions, by reducing Medicare payments to the lowest-performing hospitals by 1 percent, were also introduced. Recent data show the first-ever decline in rates of hospital-acquired conditions nationally (Blumenthal et al., 2015).

Finally, Medicare, and the majority of private insurance providers, is implementing a variety of pay-for-value programs. Starting in 2013, 1 percent of Medicare payments are redistributed to the highest performers on a composite of cost and quality measures. The program was introduced to physicians in 2015 on a voluntary basis and is expected to become mandatory by 2017. As yet, results are too preliminary to draw conclusions (Blumenthal et al., 2015).

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What is being done to reduce disparities?

There are wide disparities in the accessibility and quality of health care in the U.S. Since 2003, the annual *National Healthcare Disparities Report,* released by the Agency for Healthcare Research and Quality, has documented disparities among racial, ethnic, income, and other demographic groups and highlighted priority areas requiring action. Federally qualified health centers (FQHCs), which are eligible for certain types of public reimbursement, provide comprehensive primary and preventive care regardless of their patients' ability to pay. Initially created to provide health care to underserved and vulnerable populations, FQHCs largely provide safety-net services to the uninsured. Medicaid and CHIP provide public health insurance coverage for certain low-income populations. In addition, the ACA contains a number of provisions aimed at reducing disparities: subsidies to enable low-income Americans to purchase insurance through the exchanges; efforts to achieve parity for mental health care and substance abuse services; and additional funding to community health centers located in underserved communities. There are also a multitude of public and private initiatives at the local and state levels.

What is being done to promote delivery system integration and care coordination?

Both the government and private insurance companies are leading efforts to move away from the currently specialist-focused health system to a system founded on primary care. In particular, the "patient-centered medical home" model, with its emphasis on care continuity and coordination, has aroused interest among U.S. experts and policymakers as a means of strengthening primary care and linking medical services more closely to community services and supports.

Another trend is the proliferation of accountable care organizations (ACOs), networks of providers that assume contractual responsibility for providing a defined population with care that meets quality targets. Providers in ACOs share in the savings that constitute the difference between forecasted and actual health care spending. More than 700 ACOs have been launched by public programs and private insurers, and more than 23.5 million Americans are enrolled in one (Muhlestein, 2015). Two Medicare-driven ACO programs have been rolled out—the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Program, which together encompass more than 420 ACOs servicing 14 percent of the Medicare population, or 7.8 million Americans (Muhlestein, 2015; CMS, 2015b). Patients have reported better care experiences, quality measures have generally improved for the tracked indicators, and modest savings have been achieved (Blumenthal et al., 2015).

Medicare, Medicaid, and private purchasers, including employer groups, are also experimenting with new payment incentives that reward higher-quality, more efficient care. One strategy is "bundled payments," where a single payment is made for all the services delivered by multiple providers for a single episode of care. About 7,000 hospitals, physician organizations, and postacute care providers participate in bundled payment initiatives (Blumenthal et al., 2015).

In addition, CMS has supported the development of local programs that aim to better integrate health and social services. Among these is Massachusetts General Hospital's Care Management Program, where nurse case managers work closely with Medicare patients who have serious chronic conditions to help coordinate their medical and social care. Medicaid ACOs also are implementing programs to integrate primary care and behavioral health services. Some ACOs are not only trying to integrate clinical and social services but also exploring innovative financing models, such as cross-sectoral shared-savings models.

What is the status of electronic health records?

The 2009 American Recovery and Reinvestment Act led to significant investment (more than $30 billion) in health information technology. The legislation established financial incentives for physicians and hospitals to adopt electronic health record (EHR) systems, under what is known as the Meaningful Use Incentive Program. As of 2014, 83 percent of physicians used some form of EHR system, and three of four (76%) hospitals had

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adopted at least a basic EHR system, representing an eightfold increase since 2008 (Heisey-Grove and Patel, 2015; Charles et al., 2015).

The Meaningful Use Incentive Program is designed to gradually raise the threshold for EHR functionality above which providers receive incentives and avoid penalties. The current focus is on information exchange.

How are costs contained?

Annual per capita health expenditures in the United States are the highest in the world ($9,086 in 2013), despite a recent slowdown in spending (OECD, 2015). Payers have attempted to control cost growth through a combination of selective provider contracting, price negotiations and controls, utilization control practices, risk-sharing payment methods, and managed care. Recently, both public and private payers have focused more attention on value-based purchasing and other models that reward effective and efficient health care delivery. A movement toward favoring generic drugs over brand-name drugs, meanwhile, has led to a slowdown in pharmaceutical spending in recent years, although growth rebounded in 2014. Another growing trend is the increase in private insurance plans with high deductibles.

A number of reforms included in the ACA attempt to develop payment methods in the Medicare and Medicaid programs that reward high-quality, efficient care. Some of these use pay-for-performance mechanisms, whereas others rely on bundled payments, shared savings, or global budgets to incentivize integration and coordination among health care providers.

Despite a recent slowdown in health care spending, the latest data, through August 2015, show that spending grew 5.7 percent in the past year (Altarum Institute, 2015).

What major innovations and reforms have been introduced?

The Affordable Care Act, which ushered in a sweeping series of insurance and health system reforms aimed at achieving near-universal coverage, improved affordability, higher quality, greater efficiency, lower costs, strengthened primary and preventive care, and expanded community resources, has survived. There have been modifications to the law, however, as a result of several Supreme Court decisions since 2010. Perhaps most notable was the 2012 ruling that made the expansion of Medicaid optional for states: because of that decision, only 30 of 50 states (in addition to the District of Columbia) have pursued expansion as of late 2015.

Still, since implementation of the ACA in 2013, the number of uninsured adults has declined by historic proportions (Collins et al., 2015). Groups that have been long been at greatest risk of being uninsured—young adults, Hispanics, blacks, and those with low income—have made the greatest coverage gains (Blumenthal et al., 2015).

In 2015, the Department of Health and Human Services announced a goal to move 50 percent of Medicare payments to alternative payment models, including ACO-based arrangements, by 2018 (Blumenthal et al., 2015; Muhlestein, 2015). Medicare also has begun paying for doctors to coordinate the care of patients with chronic conditions. To be eligible for an extra $40 per patient, doctors must draft and help carry out a comprehensive plan of care for each patient who signs up for one. Under federal rules, those patients have access to doctors or other health care providers on a doctor's staff 24 hours a day, seven days a week, to deal with "urgent chronic care needs" (Edwards and Landon, 2014).

In April 2015, the Senate passed the Medicare "doc fix," averting an imminent cut in Medicare physician fees that was scheduled to occur under the now-repealed sustainable growth rate (SGR) formula. While the SGR was designed to counter the tendency toward spending growth inherent in the fee-for-service model, it was a flawed model. It was replaced by an approach focusing on rewarding high-performing providers and supporting alternative payment models (Guterman, 2015).

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/28/2017 6:06:24 PM
To: Darin Selnick [(b) (6) @gmail.com]
Subject: Re: WH Detail

Ok- it is funny to me that she is so desperate

Sent from my iPhone

> On Mar 28, 2017, at 1:24 PM, Darin Selnick <(b) (6) k@gmail.com> wrote:
>
> I received a call last night from [redacted] She was shocked that I did not want to go work at the WH and wanted to know why. I said yes, Dr. Shulkin was correct that I did not want to do a detail at the WH.
> (b) (6) told me that she talked to you on Monday, and although reluctant was now ok with me doing a 1 year detail at WH DPC to be in charge of all veterans policy.
>
> Although I was reluctant to discuss it, I agreed to meet with her later this week to talk about it. I told her I would not make a decision until after I talked to you about it and that I have big reservations about leaving VA, even for this detail.
>
> I sent (b) (6) an email requesting a 1 on 1 with you either Friday or next Monday, after I have a chance to hear their whole pitch. She seemed desperate, but there is a lot of important work going on here.
>
> Darin

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Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 3/28/2017 5:24:59 PM
To: David shulkin [Drshulkin@aol.com]
Subject: WH Detail

I received a call last night from [redacted] She was shocked that I did not want to go work at the WH and wanted to know why. I said yes, Dr. Shulkin was correct that I did not want to do a detail at the WH. (b) (6) told me that she talked to you on Monday, and although reluctant was now ok with me doing a 1 year detail at WH DPC to be in charge of all veterans policy.

Although I was reluctant to discuss it, I agreed to meet with her later this week to talk about it. I told her I would not make a decision until after I talked to you about it and that I have big reservations about leaving VA, even for this detail.

I sent (b) (6) an email requesting a 1 on 1 with you either Friday or next Monday, after I have a chance to hear their whole pitch. She seemed desperate, but there is a lot of important work going on here.

Darin

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/6/2017 5:17:45 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: can you pass this on?

Funny

Sent from my iPhone

On Apr 6, 2017, at 12:58 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

> How the tide as turned!! Boomerang!!
>
> Sent from my iPad
>
> Begin forwarded message:
>
> **From:** (b) (6) <(b) (6) evergreenpr.com>
> **Date:** April 6, 2017 at 12:53:32 PM EDT
> **To:** Poonam Alaigh <(b) (6) hotmail.com>
> **Subject: can you pass this on?**
>
> Can you let David know the NY Times is doing a profile of him and interviewed me? If he wants details, happy to share
>
> (b) (6)
> <image001.jpg>Follow Me on Twitter!
> @(b) (6)
> 51 Mt. Bethel Road
> Warren, NJ 07059
> Tel: 908-322-(b) (6)
> www.evergreenpr.com
> <image002.jpg>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/6/2017 4:58:08 PM
To: Drshulkin@aol.com
Subject: Fwd: can you pass this on?

How the tide as turned!! Boomerang!!

Sent from my iPad

Begin forwarded message:

From: (b) (6) <(b) (6) evergreenpr.com>
Date: April 6, 2017 at 12:53:32 PM EDT
To: Poonam Alaigh <(b) (6) hotmail.com>
Subject: can you pass this on?

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(b) (6)

Follow Me on Twitter!
@(b) (6)

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/5/2017 9:53:21 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Possible Prob with choice Reauthorization

That's an interesting development- CVA is supporting you. I agree that it still passes though didn't have an attachment in your email

Sent from my iPad

On Apr 4, 2017, at 10:03 PM, David shulkin <Drshulkin@aol.com> wrote:

> Wow - always interesting
>
> Lets see how the vote goes- i still think it passes - but we will see
>
> Please let Dan know I truly appreciate his support
>
> David
>
> Sent from my iPhone
>
> On Apr 4, 2017, at 9:29 PM, Darin Selnick <(b) (6) @gmail.com> wrote:
>
> > I thought you should see this development that Dan from CVA sent me. It is being circulated by the House budget committee chairwomen legislative director. CVA is supporting you and opposing this letter.
> >
> > Darin
> >
> > ---------- Forwarded message ----------
> > From: **Dan Caldwell** <dcaldwell@cv4a.org>
> > Date: Tue, Apr 4, 2017 at 6:03 PM
> > Subject: Possible Prob with choice Reauthorization
> > To: Darin Selnick <(b) (6) @gmail.com>
> >
> > This document is being circulated by the budget committee chairwoman legislative director. As you can see, there are a lot of incorrect facts in it. However this is getting sent around far and wide and may cause issues tomorrow.
> >
> > <Veterans Choice Suspension Summary.pdf>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 2:17:41 AM
To: Darin Selnick [(b) (6) [redacted]@gmail.com]
Subject: Re: Possible Prob with choice Reauthorization

Agree lets do this

Sent from my iPhone

On Apr 4, 2017, at 10:11 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:

> Agree it will pass. Red flag for me for Choice 2.0., we should consider talking with Chairwomen Diane Black, after the vote, as the budget committee could be a big problem with scoring.
>
> However, I know a staffer on the committee who tells me that the Chairwomen can get a CBO scoring waiver if they determine that CBO is wrong on the way they do the scoring. That could be important, either way I would want her on our side.
>
> Darin
>
> On Tue, Apr 4, 2017 at 7:03 PM, David shulkin <Drshulkin@aol.com> wrote:
> Wow - always interesting
>
> Lets see how the vote goes- i still think it passes - but we will see
>
> Please let Dan know I truly appreciate his support
>
> David
>
> Sent from my iPhone
>
> On Apr 4, 2017, at 9:29 PM, Darin Selnick <(b) (6) [redacted]@gmail.com> wrote:
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> > I thought you should see this development that Dan from CVA sent me. It is being circulated by the House budget committee chairwomen legislative director. CVA is supporting you and opposing this letter.
> >
> > Darin
> >
> > ---------- Forwarded message ----------
> > From: **Dan Caldwell** <dcaldwell@cv4a.org>
> > Date: Tue, Apr 4, 2017 at 6:03 PM
> > Subject: Possible Prob with choice Reauthorization
> > To: Darin Selnick <(b) (6) [redacted]@gmail.com>
> >
> > This document is being circulated by the budget committee chairwoman legislative director. As you can see, there are a lot of incorrect facts in it.

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<Veterans Choice Suspension Summary.pdf>

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Message

From: Darin Selnick [(b) (6) @gmail.com]
Sent: 4/5/2017 2:11:19 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Possible Prob with choice Reauthorization

Agree it will pass. Red flag for me for Choice 2.0., we should consider talking with Chairwomen Diane Black, after the vote, as the budget committee could be a big problem with scoring.

However, I know a staffer on the committee who tells me that the Chairwomen can get a CBO scoring waiver if they determine that CBO is wrong on the way they do the scoring. That could be important, either way I would want her on our side.

Darin

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David

Sent from my iPhone

On Apr 4, 2017, at 9:29 PM, Darin Selnick <(b) (6) @gmail.com> wrote:

> I thought you should see this development that Dan from CVA sent me. It is being circulated by the House budget committee chairwomen legislative director. CVA is supporting you and opposing this letter.
>
> Darin
>
> ---------- Forwarded message ----------
> From: **Dan Caldwell** <dcaldwell@cv4a.org>
> Date: Tue, Apr 4, 2017 at 6:03 PM
> Subject: Possible Prob with choice Reauthorization
> To: Darin Selnick <(b) (6) @gmail.com>
>
> This document is being circulated by the budget committee chairwoman legislative director. As you can see, there are a lot of incorrect facts in it. However this is getting sent around far and wide and may cause issues tomorrow.
>
> <Veterans Choice Suspension Summary.pdf>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 2:03:10 AM
To: Darin Selnick [(b) (6) @gmail.com]
BCC: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Possible Prob with choice Reauthorization

Wow - always interesting

Lets see how the vote goes- i still think it passes - but we will see

Please let Dan know I truly appreciate his support

David

Sent from my iPhone

On Apr 4, 2017, at 9:29 PM, Darin Selnick <(b) (6) @gmail.com> wrote:

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>
> <Veterans Choice Suspension Summary.pdf>

AMERICAN OVERSIGHT

Message

From: Darin Selnick [(b) (6) [redacted]@gmail.com]
Sent: 4/5/2017 1:29:29 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Fwd: Possible Prob with choice Reauthorization
Attachments: Veterans Choice Suspension Summary.pdf

I thought you should see this development that Dan from CVA sent me. It is being circulated by the House budget committee chairwomen legislative director. CVA is supporting you and opposing this letter.

Darin

---------- Forwarded message ----------
From: **Dan Caldwell** <dcaldwell@cv4a.org>
Date: Tue, Apr 4, 2017 at 6:03 PM
Subject: Possible Prob with choice Reauthorization
To: Darin Selnick <(b) (6) [redacted]@gmail.com>

This document is being circulated by the budget committee chairwoman legislative director. As you can see, there are a lot of incorrect facts in it. However this is getting sent around far and wide and may cause issues tomorrow.

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H.R. 369 will be on the Floor **tomorrow**, April 4th ***under suspension***, with brief debate and no opportunity for amendment. Debate is scheduled to begin around 2 pm, with a passage vote scheduled for 4 pm.

According to the law's own congressional Commission on Care, "**Both the design and implementation of the law have proven to be flawed.**" The report notes that the program has not solved problems, but instead "**aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike**." The Commission recommends ending the program, which was supposed to be temporary, and instead focusing on improving existing VA health services.

Sen. John McCain was the chief architect of the Veterans Choice Program, and has further legislation to expand it to cover every veteran, not just those who live far from VA facilities or have been waiting overlong for appointments. This would dramatically increase the cost of this new mandatory entitlement program.

Proponents of the bill argue that there are already 1 million veterans receiving benefits under this costly new entitlement program, and so it should be made permanent and expanded. This reasoning locks the federal government into a never-ending, ever-growing cycle of mandatory spending.

The legislation makes permanent the Veterans Choice Program, which pays for 100% of service-connected healthcare at private providers in response to the VA backlog scandal in 2014. CBO initially estimated a 10-year cost of $44 billion.

Some Members have raised concerns that the Veterans Committee's proposed plan to make reforms to the program have fallen to the wayside. They note that this bill makes none of the promised reforms and substantially expands the scope of the program and is suddenly on the Floor with no opportunity to fix problems identified by the law's own *Independent Assessment Report*.

The bill should be amended to address these concerns and ensure congress is not writing a blank check on yet another new entitlement program the government can't afford.

It should not be jammed through as a suspension where it is politically toxic to raise process concerns or suggest the bill isn't ready in its current form. Members say they don't have cover to make this case.

There was little notice to work on the issue, and time is running out to pause and fix this problem.

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 11:31:35 AM
To: IP [(b) (6)frenchangel59.com]
Subject: Re: Senate Majority Leader Mitch McConnell: New York and Palm Beach County April Travel

Thanks for updating me

Sent from my iPhone

On Apr 5, 2017, at 7:21 AM, IP <(b) (6) frenchangel59.com> wrote:

> FYI
> ---------- Forwarded message ----------
> From: (b) (6) <(b) (6) @icsgroupdc.com>
> Date: Tue, Apr 4, 2017 at 3:54 PM
> Subject: Re: Senate Majority Leader Mitch McConnell: New York and Palm Beach County April Travel
> To: L Perl <(b) (6) gmail.com>
>
> Mr. Perlmutter,
>
> Good afternoon. Thank you again for your response and continued consideration. I certainly understand. Thank you. We very much look forward to reaching out again and getting together at a future date.
>
> I commit to reaching out again when we have new dates for travel in either Palm Beach or New York.
>
> Thank you again for your time and help. We are grateful for the consideration. I look forward to talking again shortly .Have a wonderful day and rest of the week.
>
> (b) (6)
>
> [redacted]
>
> Integrated Campaign Solutions, LLC
>
> (703) 867-(b) (6) Mobile
>
> (517) 813-(b) (6) Fax
>
> (b) (6) @icsgroupdc.com
>
> ---
>
> **From:** Isaac and laura Perlmutter <(b) (6) gmail.com>
> **Date:** Tuesday, April 4, 2017 at 3:35 PM
> **To:** (b) (6) <(b) (6) @icsgroupdc.com>
> **Subject:** Re: Senate Majority Leader Mitch McConnell: New York and Palm Beach County April Travel

AMERICAN OVERSIGHT

(b) (6)

Thank you for your thoughtful response and insight. We really appreciate this explanation and detail.

That said, Laurie and I still believe that it is premature to meet with the Senator at this time.

We do look forward to a future opportunity to have dinner and develop a relationship with the Senator.

Perhaps we can begin to look for new dates in the back half of the year.

All my Best,

Ike

On Mon, Apr 3, 2017 at 11:17 PM, (b) (6) <(b) (6)@icsgroupdc.com> wrote:

Mr. Perlmutter,

Good evening. Thank you for your time and consideration. I certainly understand your concern and hesitation in engaging this early in fundraising.

While it is true that we have begun to focus our efforts in maintaining our US Senate Majority in this upcoming mid-term election and help ensure President Trump's legislative success---- the purpose of our dinner was **NOT** to ask for any specific contribution.

The purpose of the dinner was to spend a bit of time with you and Mrs. Perlmutter, to develop a relationship and discuss the upcoming legislative/political landscape.

If you were willing to still have dinner with the Leader on his upcoming visit, **I commit to you that no specific request for resources will be made during our visit.**

I understand that you and Mrs. Perlmutter are extremely busy. I very much respect and understand and your hesitation. Again, no request will be made next week. I hope we still have the opportunity to visit.

Thank you again for your continued time and consideration. I look forward to talking again shortly.

Have a wonderful night!

(b) (6)

(b) (6)
Mobile: (703) 867-(b) (6)
Fax: (517) 813-(b) (6)

AMERICAN OVERSIGHT

On Apr 3, 2017, at 9:46 PM, L Perl <(b) (6) gmail.com> wrote:

(b) (6)

Unfortunately, Laurie and I are going to have to postpone our dinner with you and Senator McConnell.

We were not aware that the purpose and focus of our dinner was fundraising. It is premature for us to engage on this topic at this time. We look forward to rescheduling our dinner and this discussion to a later date.

Please pass along our regrets and best wishes to the Senator.

All my Best,

Ike

On Sun, Apr 2, 2017 at 7:41 PM, (b) (6)
<(b) (6) @icsgroupdc.com> wrote:

Mrs. Perlmutter,

Good evening. Perfect. Sounds terrific.

Thanks again for your time and help. We are grateful for your consideration.

Look forward to seeing you shortly. Have a wonderful night!

(b) (6)

(b) (6)

Mobile: (703) 867-(b) (6)

Fax: (517) 813-(b) (6)

Sent from my iPhone

On Mar 31, 2017, at 5:36 PM, L Perl <(b) (6) gmail.com> wrote:

> We are looking forward to meeting the Senator. Yes-- we are still planning

AMERICAN OVERSIGHT

on dinner at Mar-a-Lago at 7;15.

If the weather is nice, which it should be--- dinner will be outside on the

terrace. If raining, then we will be in the main dining room.

Have a nice weekend....Best....LP

On Fri, Mar 31, 2017 at 8:33 AM, (b) (6) [redacted] <(b) (6) [redacted]@icsgroupdc.com> wrote:

Mrs. Perlmutter,

Good morning. I hope that you are having a wonderful week. I wanted to circle back on our upcoming dinner in Palm Beach on Wednesday, April 12, 2017. Is your preference still Mar-a-Lago at 7:15pm? Also, will the dinner take place at the Main Dining Room?

I understand that you are incredibly busy, but if you could please reconfirm the time and location for our dinner, I would be immensely grateful.

Thank you again for everything. I look forward to talking again shortly.

Have a wonderful day and weekend!

(b) (6) [redacted]

[redacted]

Integrated Campaign Solutions, LLC

AMERICAN OVERSIGHT

(703) 867-[redacted] Mobile

(517) 813-[redacted] Fax

[redacted]@icsgroupdc.com

From: Isaac and laura Perlmutter <[redacted]gmail.com>
Date: Thursday, March 2, 2017 at 6:08 PM
To: [redacted] <[redacted]@icsgroupdc.com>
Subject: Re: Senate Majority Leader Mitch McConnell: New York and Palm Beach County April Travel

We will probably plan dinner at Mar-a-Lago-- around 7:15 that evening.

Will confirm this as we get closer to the date....Best...LP

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>
> Good afternoon. Perfect. I will confirm our dinner. Thank you for your continued time and help! Two final questions:
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> Would you like to have dinner at your home? If so, could you please reconfirm the address? Also, US Capital police always advances the Leader's travel. Is there a security contact that I can pass along to US Capitol Police?
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> [redacted]

From: Isaac and laura Perlmutter <[redacted]gmail.com>
Date: Thursday, March 2, 2017 at 4:24 PM
To: [redacted] <[redacted]@icsgroupdc.com>
Subject: Re: Senate Majority Leader Mitch McConnell: New York and Palm Beach County April Travel

AMERICAN OVERSIGHT

Dinner on Wednesday 4/12 is fine...we look forward to it...

Thanks..LP

AMERICAN OVERSIGHT

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[redacted]

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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Thanks..LP

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 10:43:32 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: Delaware Presentation.

Agreed

Sent from my iPhone

On Mar 31, 2017, at 4:41 PM, (b) (6) <(b) (6) gmail.com> wrote:

> (b) (6) hasn't taken my advice yet for moaa, so we don't have anything to share yet.
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> On Mar 31, 2017 4:07 PM, "David shulkin" <Drshulkin@aol.com> wrote:
> I like it! Very good
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> > let me know what you think of this version.
> > <2017 04 03 -3 DELAWARE VETERANS SUMMIT without video.pptx>

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AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 8:07:47 PM
To: (b) (6) [(b) (6) gmail.com]
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>
> let me know what you think of this version.
> <2017 04 03 -3 DELAWARE VETERANS SUMMIT without video.pptx>

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 3/31/2017 7:37:19 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Delaware Presentation.
Attachments: 2017 04 03 -3 DELAWARE VETERANS SUMMIT without video.pptx

let me know what you think of this version.

AMERICAN OVERSIGHT

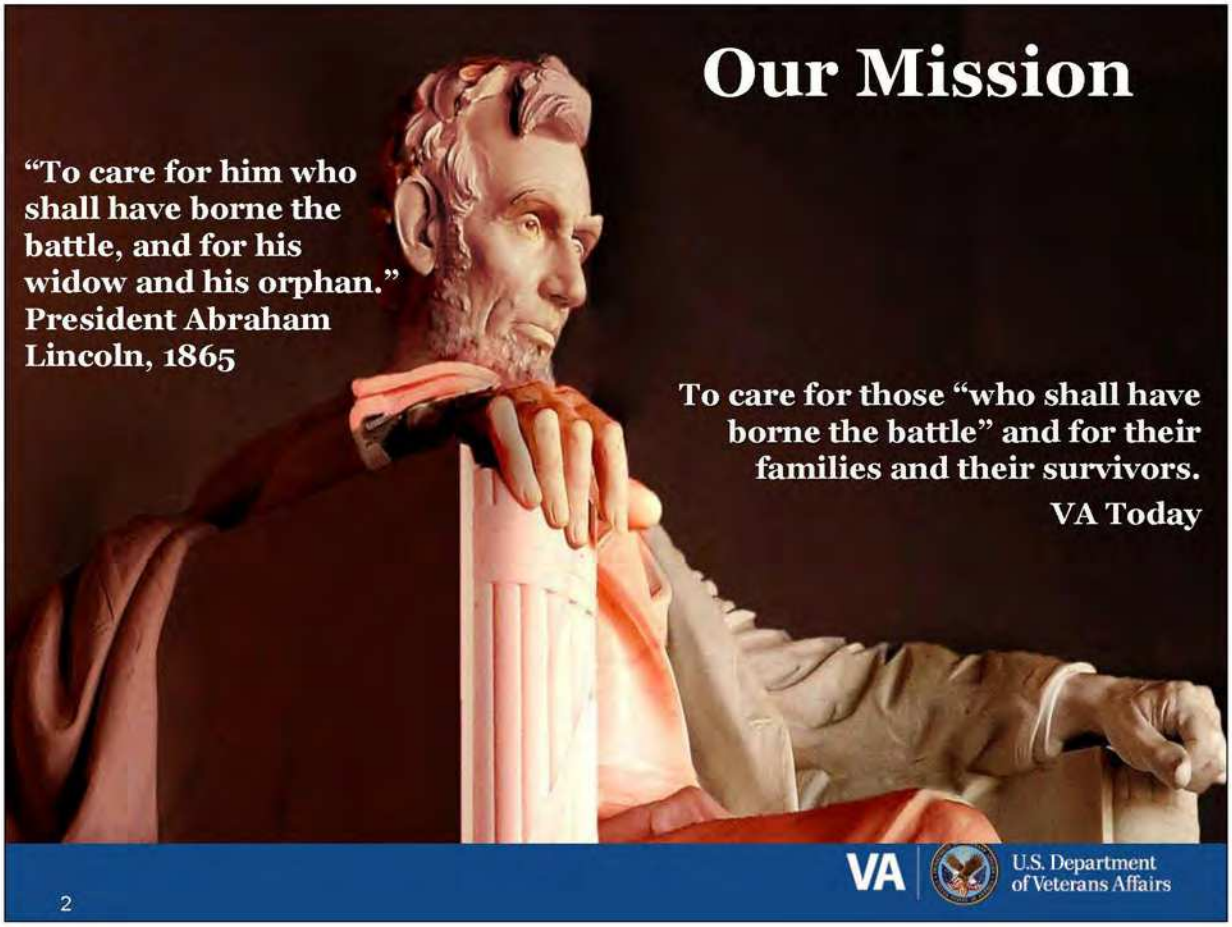
VA | U.S. Department of Veterans Affairs

Secretary's 10 Priorities
Delaware Veterans Summit

David J. Shulkin, M.D.
Secretary of Veterans Affairs

April 3, 2017

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Ending Homelessness for Veterans



THE MAYORS CHALLENGE
END VETERAN HOMELESSNESS

DELAWARE JOINING FORCES

- 3 States
- 42 Communities





VA | U.S. Department of Veterans Affairs

3

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Partnerships Create Change



Stakeholders are critical to VA's success

VA | U.S. Department of Veterans Affairs

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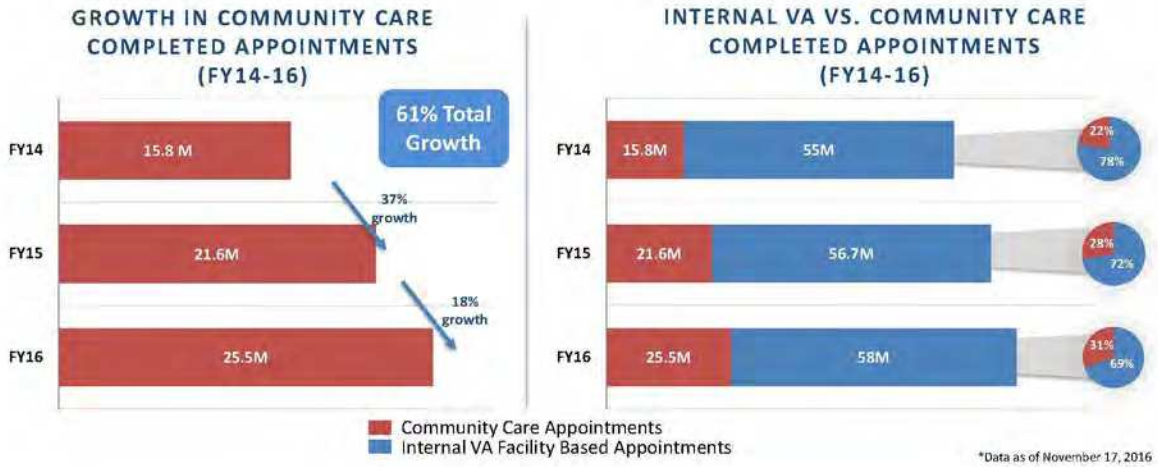
Priority 1: Extend the Choice Deadline



U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Choice 2.0 Legislation

1. Maintain a high-performing integrated network that includes VA, federal partners, academic affiliates, and community providers
2. Increase choice for all Veterans, starting with those with service-connected conditions
3. Ensure Veterans get the care they need, closer to home when appropriate
4. Optimize coordination of VA healthcare with the health insurance Veterans already have
5. Maintain affordability of healthcare options for low-income Veterans
6. Assist in coordinating care for Veterans served by multiple providers
7. Apply industry standards for performance, quality, patient satisfaction, payment models, and health outcomes

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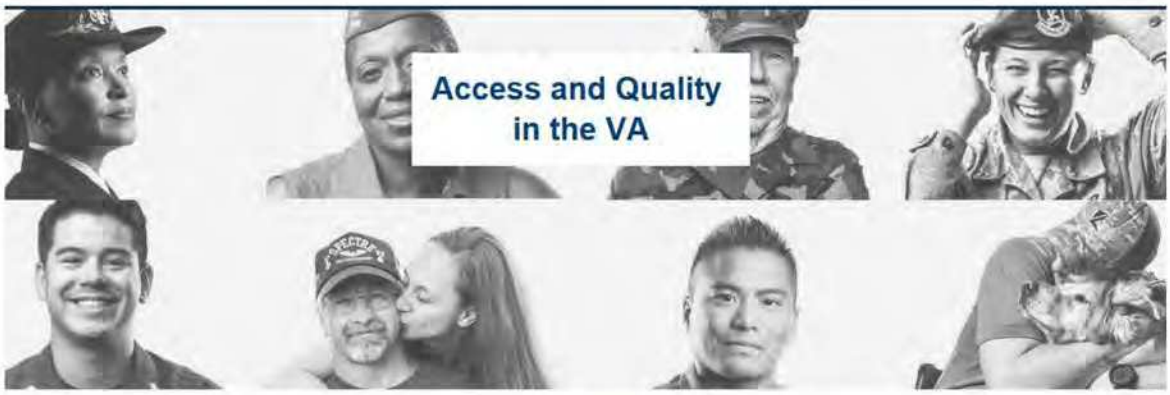
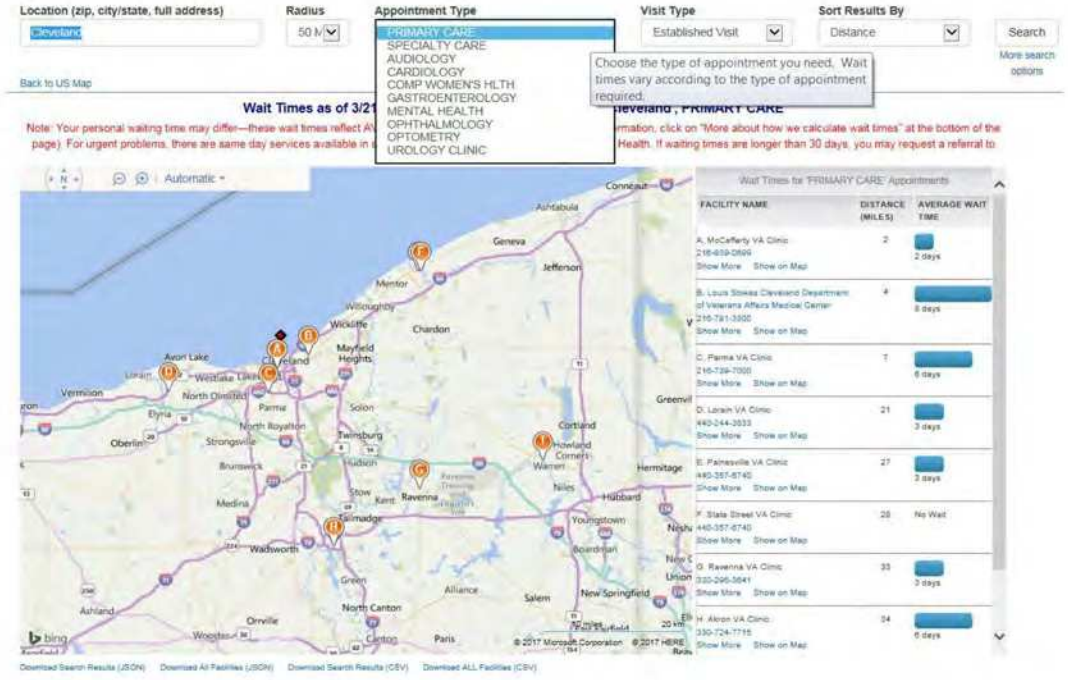


Access and Quality in the VA

How quickly does my VA see patients?	How satisfied are veterans like me with the timeliness of their care?	How well does my VA's care compare to other hospitals?

AMERICAN OVERSIGHT

Wait Times for Appointments at VA Facilities



U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

What Veterans Say About Access to Care at VA facilities

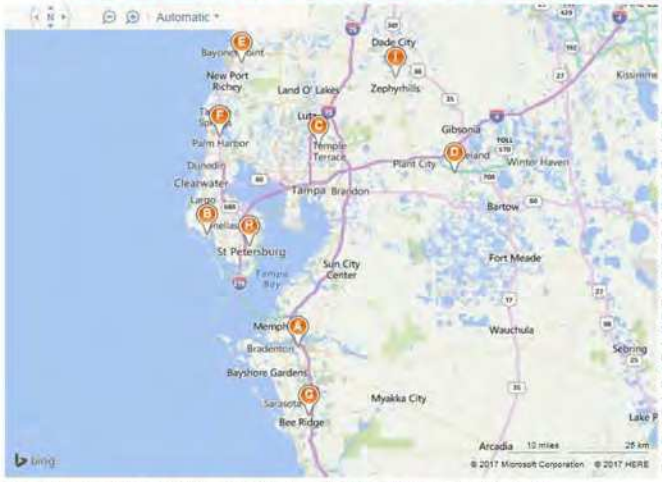
Location (zip, city/state, full address): BAY PINES | Radius: 50 Miles | Appointment Type: Primary Care (Routine) | Sort Results By: Facility Name | Search

Back to US Map

Found facilities will be ordered according to your choice here

Percent of Veterans who reported that they were Always or Usually able to get an appointment when needed. The 7/1/2016 - 12/31/2016. At least 30 Veterans have responded to this question for a site to be included. The filters used to search are: 50 mile radius of 'BAY PINES', Primary Care (Routine)

Note – The data shows what Veterans have said about their own Access experiences over the preceding 6 months. Your own experience may be different. For urgent problems, there often are options to be seen sooner, such as a same-day clinic. If your wait will be longer than 30 days, you may request a referral to Care in the Community.



Percent of Veterans who reported that they were Always or Usually able to get an appointment when needed for 'Primary Care (Routine)' Appointments

FACILITY NAME	DISTANCE IN MILES	PRIMARY CARE (ROUTINE)
A. Bradenton VA Clinic 941-721-0649 Show More Show on Map	26	89 %
B. C.W. Bill Young Department of Veterans Affairs Medical Center 727-398-6661 Show More Show on Map	0	85 %
C. James A. [redacted] Veterans' Hospital 813-972-2000 Show More Show on Map	28	87 %
D. Lakeland VA Clinic 863-701-2470 Show More Show on Map	49	84 %
E. New Port Richey VA Clinic 727-869-4100 Show More Show on Map	34	86 %
F. Palm Harbor VA Clinic 727-734-5276 Show More Show on Map	19	82 %
G. Sarasota VA Clinic	41	89 %

Download Search Results (JSON) Download All Facilities (JSON) Download Search Results (CSV) Download ALL Facilities (CSV)

U.S. Department of Veterans Affairs

9

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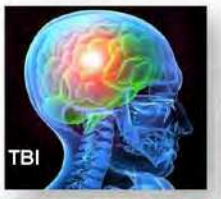
Priority #3: Enhancing Foundational Services











VA U.S. Department of Veterans Affairs

AMERICAN OVERSIGHT

Priority #4: Accountability Legislation

1. Increased flexibility to remove, demote, or suspend VA employees for poor performance or misconduct
2. Authority to recoup bonuses of employees for poor performance or misconduct
3. Authority to recoup relocation expenses authorized through fraud or malfeasance
4. Authority to reduce federal pensions for employees convicted of felonies
5. Increased protections for whistleblowers

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Priority #5: Infrastructure Improvements



Officers' Quarters
Fort Thomas, KY
Circa 1895



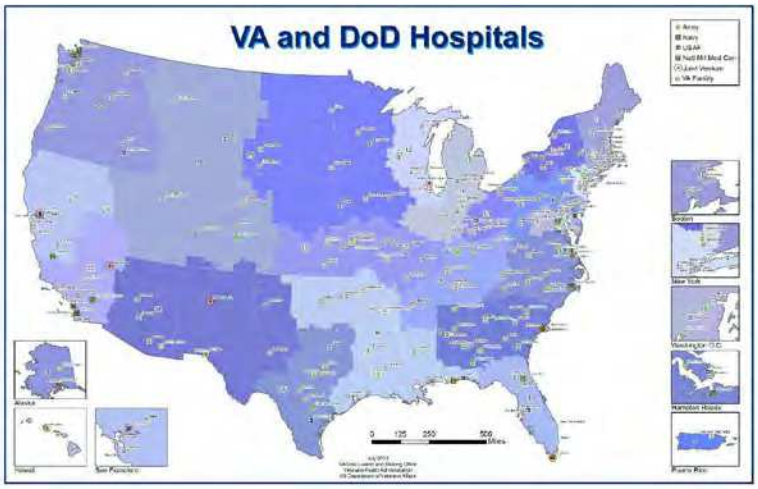
Gas Station
Minneapolis, MN
1932



Palo Alto VAMC
2017

AMERICAN OVERSIGHT

Priority #6: VA/DoD/Federal Coordination



VA | U.S. Department of Veterans Affairs

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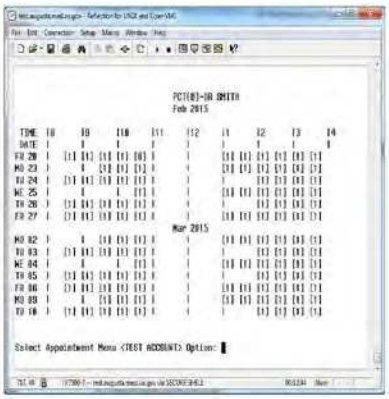
Priority #7: EMR Interoperability & Modernization



VistA Legacy Scheduling

VistA Scheduling Enhancement



VA U.S. Department of Veterans Affairs

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Priority #8: Suicide Prevention



VA | U.S. Department of Veterans Affairs

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Mental Health PSA



16

The video will play as soon as you cue the next slide.

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Priority #9: Accelerating Performance on Claims



Decision Ready Claims (DRC)

- Actively engage Veterans in the claims process.
- Enhance access & capabilities of VSOs in the submission of DRC.
- Expand partnership with VSOs to assist in the acceleration and performance of disability claims.
- Successful participation in the DRC program will result in a claim decision within 30 days of submission.

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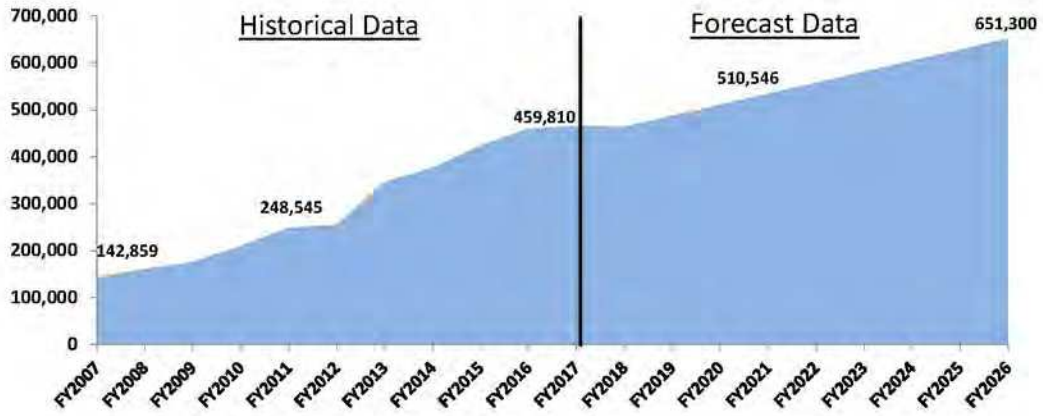
Priority #10: Appeals Modernization



VA U.S. Department of Veterans Affairs

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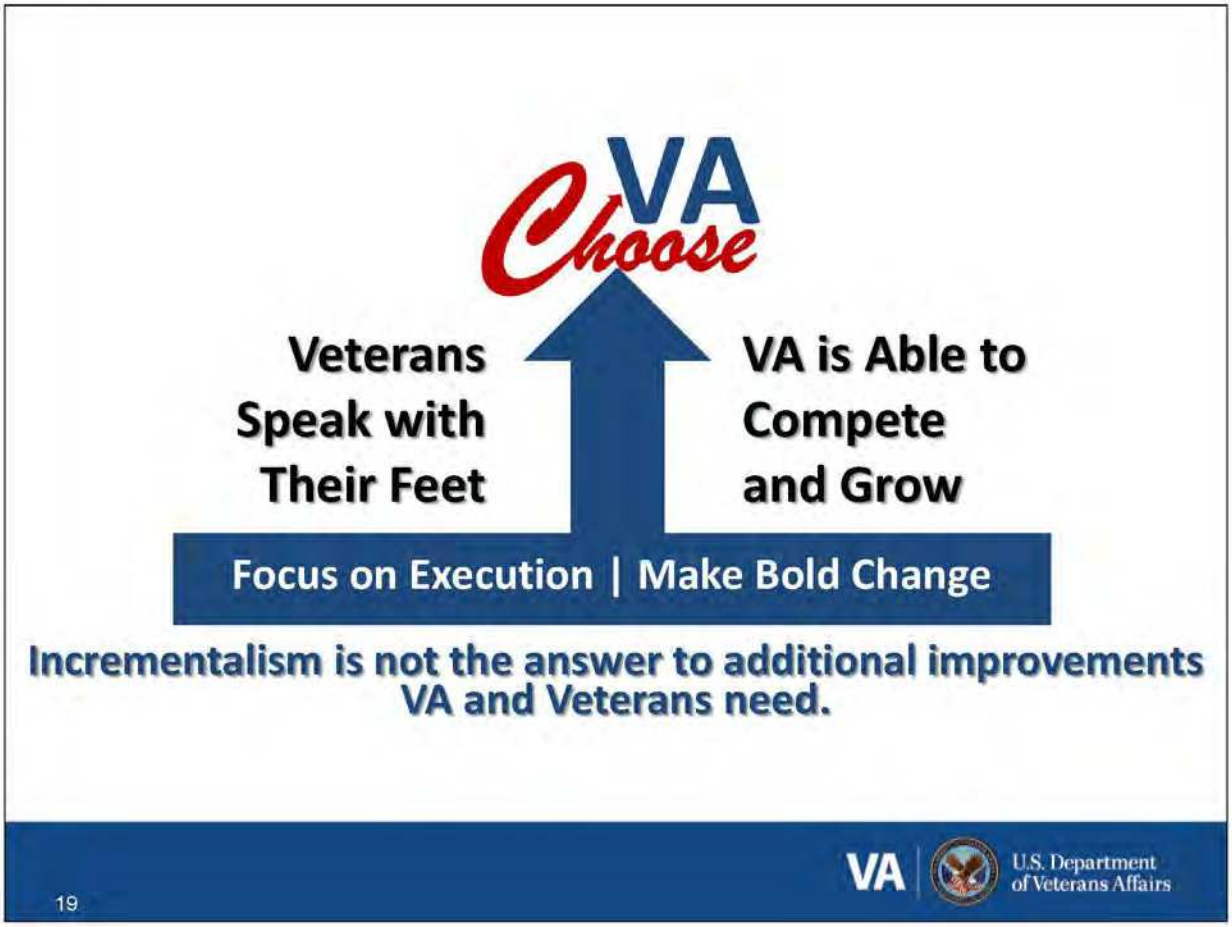

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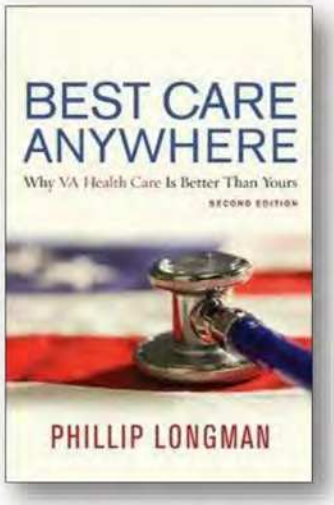
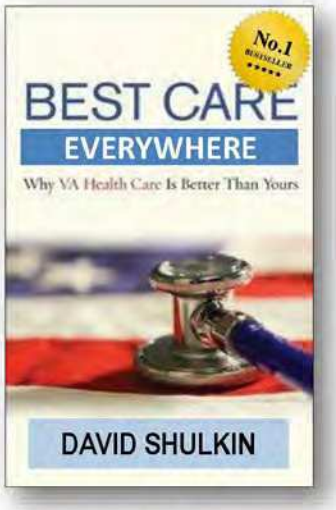


Best Practices



One single high-performance, clinically integrated network

VA | U.S. Department of Veterans Affairs

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 11:57:09 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re:

What did they do?

Sent from my iPhone

On Apr 3, 2017, at 6:58 PM, (b) (6) <(b) (6) gmail.com> wrote:

> Darin and Mike L.
>
> On Apr 3, 2017 6:50 PM, "David shulkin" <Drshulkin@aol.com> wrote:
> Who are we talking about?
>
> Sent from my iPhone
>
> On Apr 3, 2017, at 6:22 PM, (b) (6) <(b) (6) gmail.com> wrote:
>
> > Sorry these* people.
> >
> > On Apr 3, 2017 6:21 PM, "(b) (6)
> > <(b) (6) gmail.com> wrote:
> > This people are such snakes.

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/3/2017 10:58:58 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re:

Darin and Mike L.

On Apr 3, 2017 6:50 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Who are we talking about?

Sent from my iPhone

On Apr 3, 2017, at 6:22 PM, [redacted] <[redacted]gmail.com> wrote:

Sorry these* people.

On Apr 3, 2017 6:21 PM, "[redacted] <[redacted]gmail.com> wrote:
This people are such snakes.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/3/2017 10:50:16 PM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re:

Who are we talking about?

Sent from my iPhone

On Apr 3, 2017, at 6:22 PM, (b) (6) <(b) (6) gmail.com> wrote:

> Sorry these* people.
>
> On Apr 3, 2017 6:21 PM, "(b) (6) <(b) (6) gmail.com> wrote:
> This people are such snakes.

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/3/2017 10:22:13 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Re:

Sorry these* people.

On Apr 3, 2017 6:21 PM, "[redacted]" <[redacted]gmail.com> wrote:
This people are such snakes.

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 4/3/2017 10:21:55 PM
To: David Shulkin [drshulkin@aol.com]

This people are such snakes.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/2/2017 9:52:29 PM
To: bruce moskowitz [(b) (6) gmail.com]
CC: drshulkin@aol.com
Subject: Re: Philadelphia VA letter from Dr. (b) (6)

This is awesome- we have a call scheduled this week once I am back- let's discuss both R&D and the residency/training opportunity.

David, Bruce and I have a call on Thursday and will fill you in on it.

Sent from my iPhone

On Apr 1, 2017, at 1:23 AM, bruce moskowitz <(b) (6) gmail.com> wrote:

> The best part of this is it requires no funding for each position! I found a donor source.
>
> Sent from my iPhone
>
> On Mar 31, 2017, at 6:27 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Bruce - we are looking for different approaches to increasing our residencies and medical school training while creating new models of collaboration with our academic affiliates- real situations like you have identified below are going to be an important part of our discussion. Thanks so much for sending this along.
> >
> > Sent from my iPhone
> >
> > On Mar 31, 2017, at 5:20 PM, Bruce Moskowitz <(b) (6) gmail.com> wrote:
> >
> > > There is an estimated 700 medical students like this without residency positions. The VA in Philadelphia would like to have this resident but I am not sure how to make it happen. Thanks for reviewing.
> > >
> > > Sent from my iPad
> > > Bruce Moskowitz M.D.
> > >
> > > Begin forwarded message:
> > >
> > > **From:** "(b) (6) <(b) (6) va.gov>
> > > **Date:** March 31, 2017 at 11:57:33 AM EDT
> > > **To:** "Brucem(b) (6) @gmail.com" <Brucem(b) (6) @gmail.com>
> > > **Cc:** "(b) (6) <(b) (6) uphs.upenn.edu>
> > > **Subject: Reference for** (b) (6)

AMERICAN OVERSIGHT

Dear Dr. Moskowitz,

My name is [redacted] and I am the Section Chief of Hospital Medicine at the Corporal Michael J. Crescenz VAMC (Philadelphia VAMC). I have worked with [redacted] extensively on the wards during her sub-internship in medical school and she asked me to reach out to you as a reference. I have attached the letter of recommendation I wrote in support of her candidacy for residency. To summarize that letter, [redacted] is one of the most exceptional medical students I have worked with from the Perelman School of Medicine at the University of Pennsylvania. She is exceedingly intelligent, dedicated and passionate in her work, an absolutely exceptional colleague and was a vital member of our care team.

I am not alone in saying that we would support her interest in doing a prelim year at a VAMC and that she would be an outstanding addition to any residency program. I have cc'd this email to the University of Pennsylvania's Site Lead for Undergraduate Medical Education here at CMCVAMC, Dr. [redacted] who concurs with this assessment and can vouch for the type of high quality academic, clinical and personal qualities [redacted] demonstrates.

Please let us know if and how we can help, we are happy to assist.

Sincerely,

[redacted] MD
Section Chief of Hospital Medicine
Corporal Michael J. Crescenz VAMC
Philadelphia, VA
215-823-[redacted] (Office)
703-217-[redacted] (Cell)

Clinical Assistant Professor of Medicine
Division of General Internal Medicine
Perelman School of Medicine
University of Pennsylvania

<LOR [redacted] residency by MTG.pdf>

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/1/2017 12:09:48 PM
To: bruce moskowitz [(b) (6) gmail.com]
Subject: Re: Philadelphia VA letter from Dr. (b) (6)

You are amazing!

Sent from my iPhone

On Mar 31, 2017, at 8:23 PM, bruce moskowitz <(b) (6) gmail.com> wrote:

> The best part of this is it requires no funding for each position! I found a donor source.
>
> Sent from my iPhone
>
> On Mar 31, 2017, at 6:27 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Bruce - we are looking for different approaches to increasing our residencies and medical school training while creating new models of collaboration with our academic affiliates- real situations like you have identified below are going to be an important part of our discussion. Thanks so much for sending this along.
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> >
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> > > Bruce Moskowitz M.D.
> > >
> > > Begin forwarded message:
> > >
> > > **From:** "(b) (6) <(b) (6) va.gov>
> > > **Date:** March 31, 2017 at 11:57:33 AM EDT
> > > **To:** "(b) (6) gmail.com" <(b) (6) gmail.com>
> > > **Cc:** "(b) (6) <(b) (6) uphs.upenn.edu>
> > > **Subject: Reference for** (b) (6)
> > >
> > > Dear Dr. Moskowitz,
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> > > My name is (b) (6) and I am the Section Chief of Hospital Medicine at the Corporal Michael J. Crescenz

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VAMC (Philadelphia VAMC). I have worked with [redacted] extensively on the wards during her sub-internship in medical school and she asked me to reach out to you as a reference. I have attached the letter of recommendation I wrote in support of her candidacy for residency. To summarize that letter, [redacted] is one of the most exceptional medical students I have worked with from the Perelman School of Medicine at the University of Pennsylvania. She is exceedingly intelligent, dedicated and passionate in her work, an absolutely exceptional colleague and was a vital member of our care team.

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Please let us know if and how we can help, we are happy to assist.

Sincerely,

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Section Chief of Hospital Medicine
Corporal Michael J. Crescenz VAMC
Philadelphia, VA
215-823-[redacted] (Office)
703-217-[redacted] (Cell)

Clinical Assistant Professor of Medicine
Division of General Internal Medicine
Perelman School of Medicine
University of Pennsylvania

<LOR MR residency by MTG.pdf>

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Message

From: bruce moskowitz [(b) (6) gmail.com]
Sent: 4/1/2017 12:23:52 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
CC: drshulkin@aol.com
Subject: Re: Philadelphia VA letter from Dr. (b) (6)

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Sent from my iPhone

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> > Begin forwarded message:
> >
> > **From:** "(b) (6) <(b) (6) va.gov>
> > **Date:** March 31, 2017 at 11:57:33 AM EDT
> > **To:** "(b) (6) gmail.com"
> > <(b) (6) gmail.com>
> > **Cc:** "(b) (6)
> > <(b) (6) uphs.upenn.edu>
> > **Subject: Reference for** (b) (6)
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Section Chief of Hospital Medicine
Corporal Michael J. Crescenz VAMC
Philadelphia, VA
215-823-(b) (6) (Office)
703-217-(b) (6) (Cell)

Clinical Assistant Professor of Medicine
Division of General Internal Medicine
Perelman School of Medicine
University of Pennsylvania

<LOR (b) (6) residency by MTG.pdf>

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Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/31/2017 10:27:42 PM
To: Bruce Moskowitz [(b) (6) gmail.com]
CC: drshulkin@aol.com
Subject: Re: Philadelphia VA letter from Dr. (b) (6)

Bruce - we are looking for different approaches to increasing our residencies and medical school training while creating new models of collaboration with our academic affiliates- real situations like you have identified below are going to be an important part of our discussion. Thanks so much for sending this along.

Sent from my iPhone

On Mar 31, 2017, at 5:20 PM, Bruce Moskowitz <(b) (6) gmail.com> wrote:

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Corporal Michael J. Crescenz VAMC
Philadelphia, VA
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703-217-[redacted] (Cell)

Clinical Assistant Professor of Medicine
Division of General Internal Medicine
Perelman School of Medicine
University of Pennsylvania

<LOR [redacted] residency by MTG.pdf>

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Message

From: David Shulkin [drshulkin@aol.com]
Sent: 3/27/2017 2:14:32 AM
To: (b) (6) gmail.com
Subject: Fwd: slides
Attachments: ache2017.pptx

I will use the ACHE presentation for the chief medical officer and nurse executive lecture this week as well

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Lessons from 810 Vermont and Beyond

David J. Shulkin MD

The 9th Secretary of US Department of Veterans Affairs

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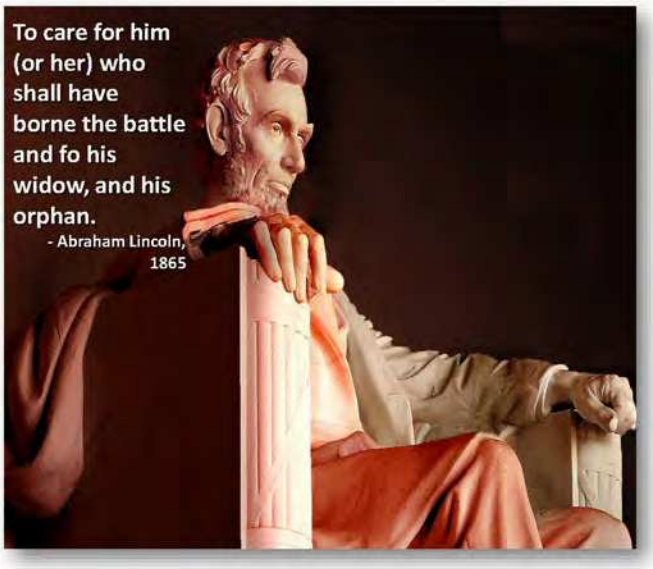

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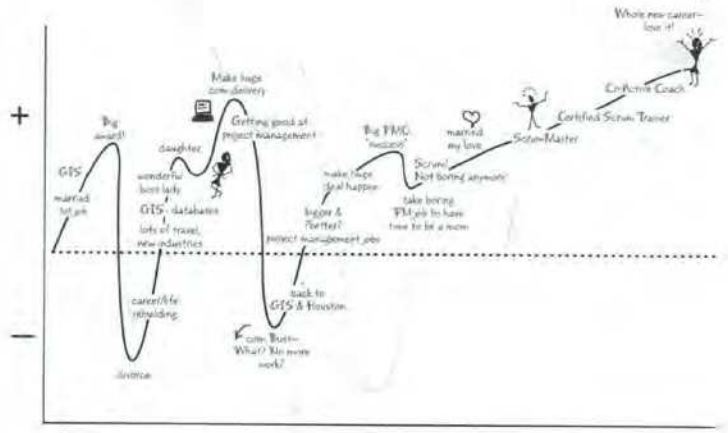
Share Your Journey



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Paving Attention to Culture

'Final Salute' honors Holocaust survivor, Veteran



Sailors wait in a hallway on the medical-surgical floor at Lovell FHCC for the body of Holocaust survivor and Korean War Air Force Veteran Paul Argenicz to be wheeled to the elevators. (Photo by Trevor Seda)

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Living with purpose is more rewarding than meandering around







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Get Out of the Office





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Learning Medicine on the Ski Slopes





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VA's Definition of Health

	Private Sector	Veterans Health Administration
Peer Support		X
Crisis Lines		X
Transportation		X
Caregivers		X
Homelessness Services		X
Medication Support		X
Behavioral Health Integration		X
Aligned Incentives		X
Lifelong Relationships		X
Single EMR Platform		X
Works with Most Leading Medical Centers		X
Vocational Support		X

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Leaders Ask the Right Questions
Two Things Every Leader Needs to Know

- Am I pushing too hard or am I not pushing hard enough?

- What don't I know that is likely to damage the organization?

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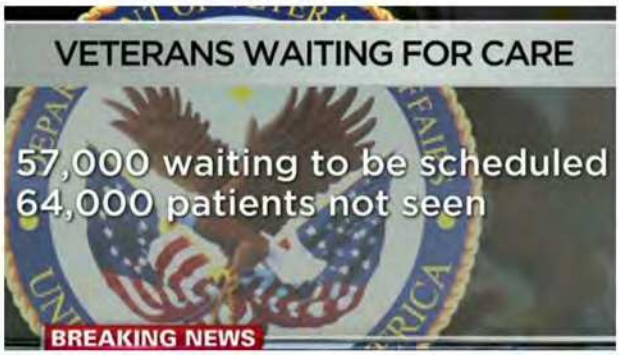
Ask the Right Questions
600,000 Veterans Waiting for Care





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FOCUS ON WHAT IS IMPORTANT



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Set Big Goals



Talk to your Patient Aligned Care Team (PACT) or your Mental Health Team to learn about your options and timely access to care when you need it.

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Run Towards the GunFire





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Be Present



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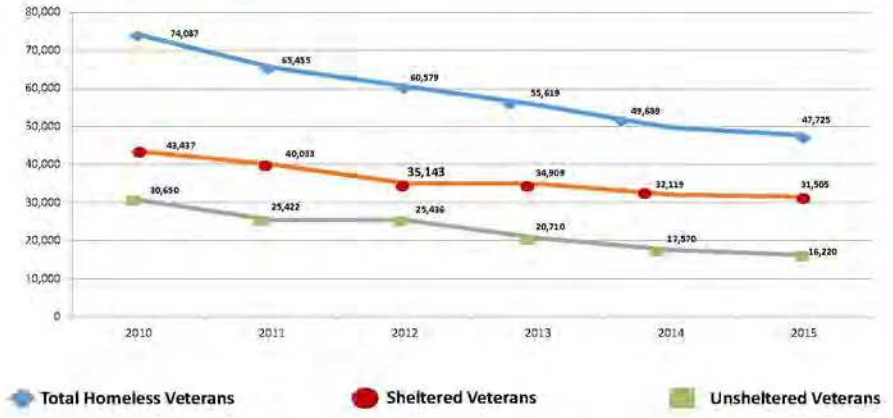
Decline in Homelessness





17

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Focus on Our People





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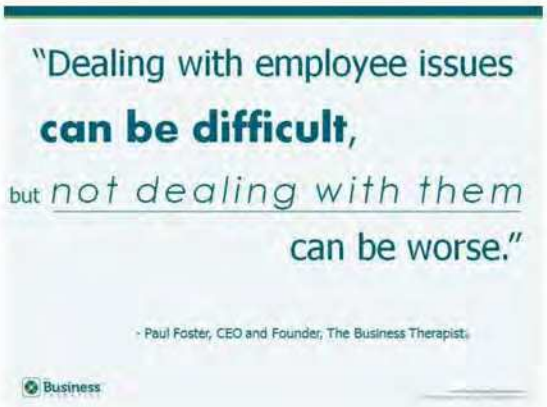
Rid Organizations of Bad Actors (Stop the Detailing)



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Little Stuff Matters

Thank You



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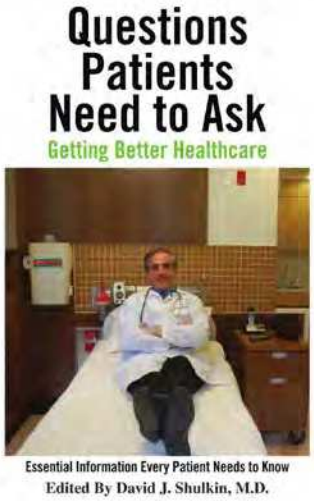
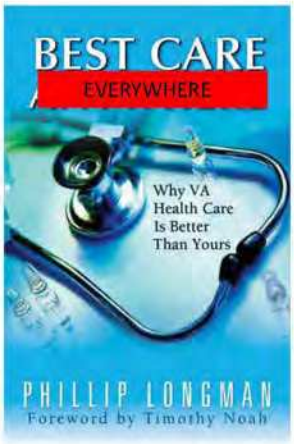
Get Everyone's Ideas





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Invest in others and develop them



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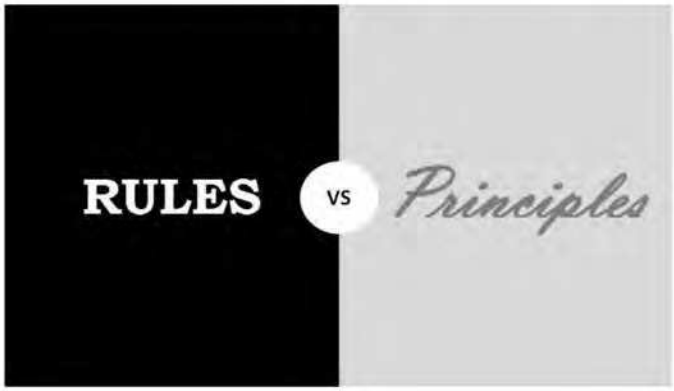
Principle Based (vs. Rules Based) Organizations





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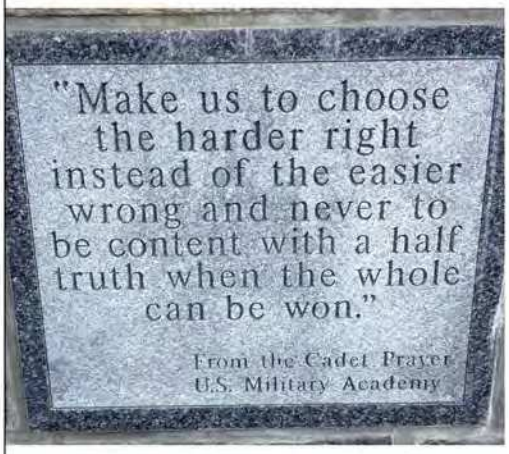
Choose the Hard Right than the Easier Wrong





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Walk the Talk-Practicing in NY and Oregon





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Leaders Propose Solutions , not Criticize



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Getting People to Be Part of the Solution



28

On February 2, 2016, VA hosted a summit, "Preventing Veterans Suicide – A Call to Action" to bring together Veterans, families, federal agencies, community providers, subject matter experts, and other key stakeholders to enhance suicide prevention efforts.

The summit generated a new framework for VA's approach to Suicide Prevention that will transform the vision and structure of suicide prevention across VA and the community.

VA has elevated and expanded our Suicide Prevention Program to fulfill this vision, which includes:

Meeting urgent mental health needs by providing Veterans same-day evaluations and access by the end of calendar year 2016.

Building and leveraging strategic partnerships to disseminate new initiatives within VA and to reach non-VA using Veterans.

Development and implementation of innovative life-saving programs, such as REACH-VET, which uses predictive modeling to identify Veterans at high risk for suicide.

Continuing to partner with the Department of Defense for a seamless transition from military service to civilian life.

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Making Tough Decisions



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"It takes an Act of Congress"

30

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APRNS- 300k comments



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Challenge the Status Quo



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Innovations from VA



First Liver Transplant


CT Scanner


Artificial Kidney


7 Lasker Awards


3 Nobel Prizes


Nicotine Patches


Cardiac Pacemaker

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Center for Compassionate Innovation @ VA

To enhance veteran's health and well being by offering safe and ethical therapies after traditional treatments have not been successful



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35

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Effective Organizations Break Down Silos





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Don’t take no for an answer



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Decline in Opioid Use Since 2012

Opioid use: ↓ **31% to 471,340 Veterans on opioid**

Long-term opioid use: ↓ **36% to 281,029 Veterans on LOT**

Benzo co-prescribing: ↓ **56% to 53,485 Veterans**

High dose (>100 mg MEDD*): ↓ **44% to 33,149 Veterans**

Annual drug screening: ↑ **From 37% to 86%**



*MEDD = Morphine Equivalent Daily Dosage

38

Decline in opioid use, 4Q FY 2012 to 1Q FY 2017.

AMERICAN OVERSIGHT

Have a Work Life Balance – Family Time









AMERICAN OVERSIGHT

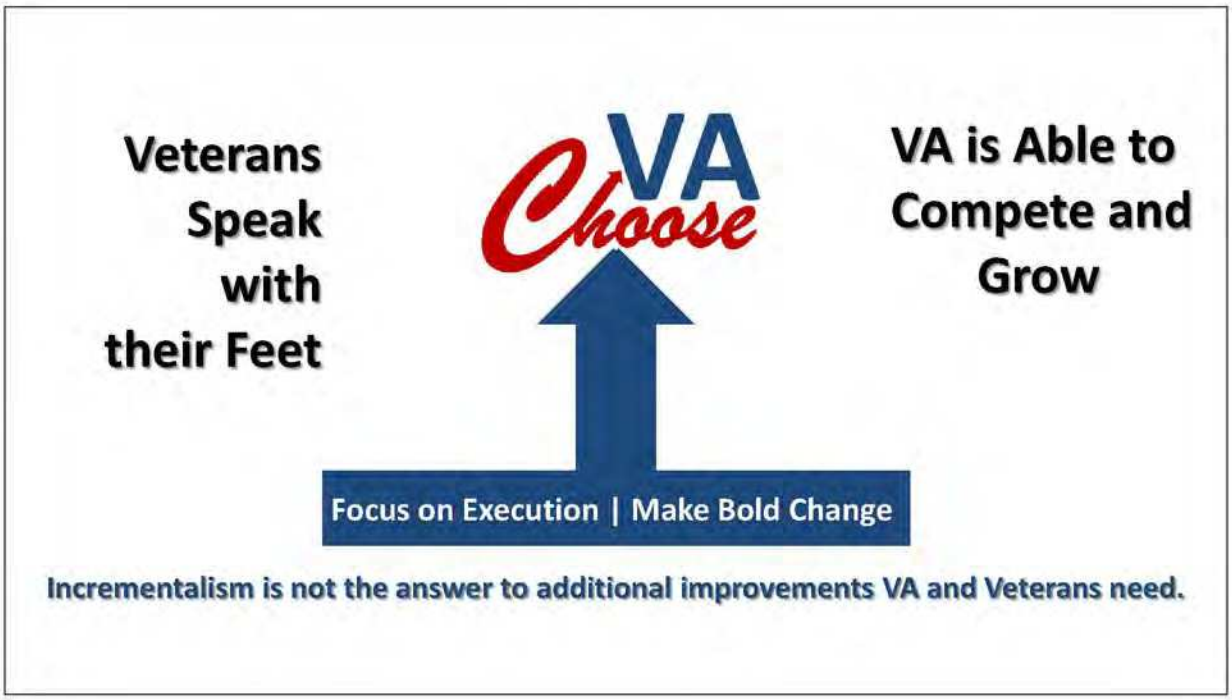
Have Fun







AMERICAN OVERSIGHT

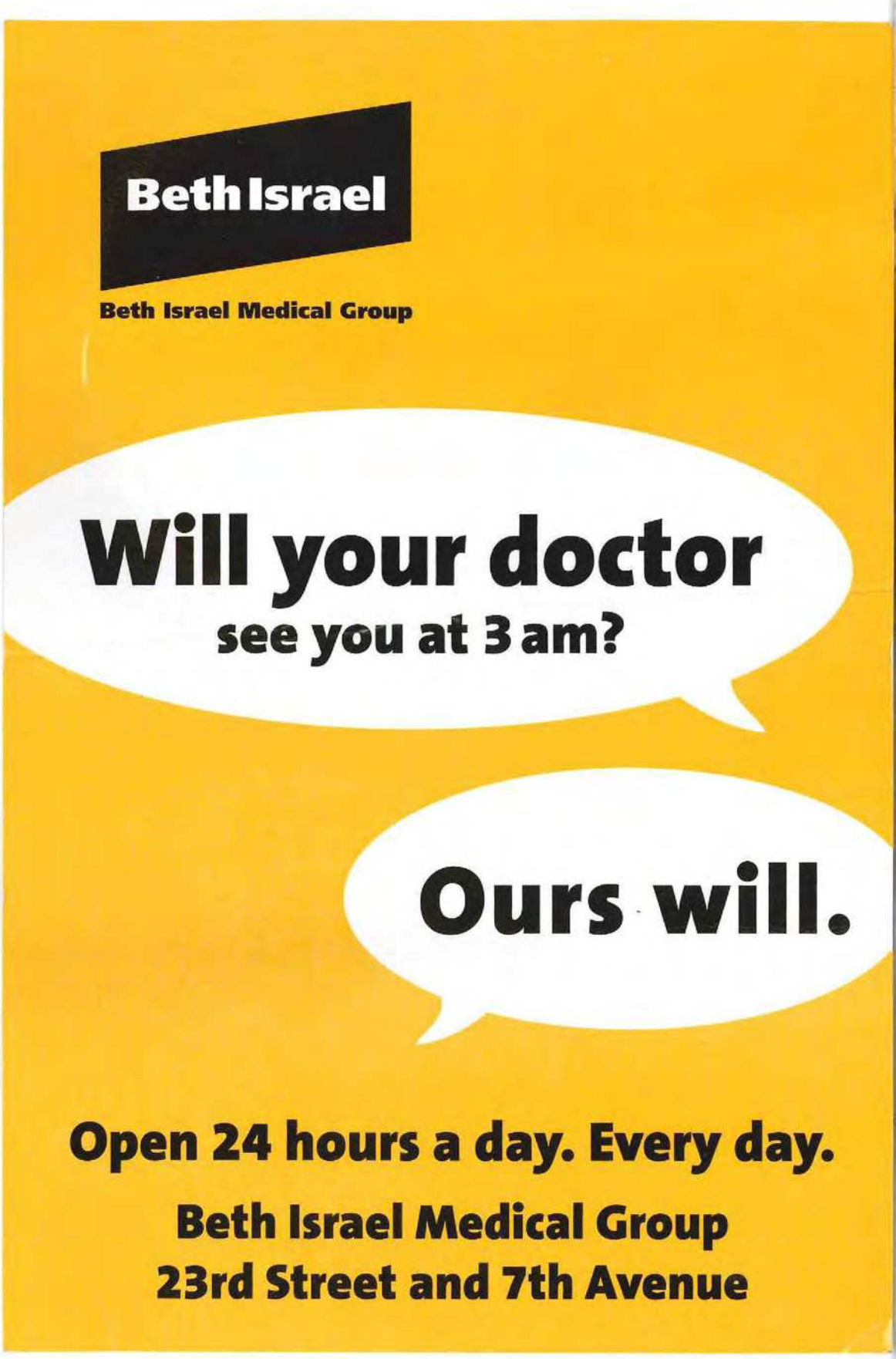


AMERICAN OVERSIGHT

The Secretary's 10 Priorities

- Extend Choice beyond August 2017
- Choice 2.0 Legislation: Eliminate the 40/30 Rule
- Infrastructure Improvements and Consolidations
- Enhance Foundational Services in VA
- VA/DOD/Federal Coordination
- EMR Interoperability and Modernization
- Breakthrough in Suicide Prevention
- Appeals Modernization
- Accelerating VBA Performance on Claims
- Accountability Legislation

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/30/2017 12:10:37 PM
To: [redacted]sunnyshulkin.com
Subject: Re: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

Did you click the link and then the listen button to hear the interview?

Sent from my iPhone

On Mar 30, 2017, at 7:07 AM, <[redacted]sunnyshulkin.com> <[redacted]sunnyshulkin.com> wrote:

> Great news! Love, [redacted]
>
> -------- Original Message --------
> Subject: Fwd: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR
> From: David shulkin <Drshulkin@aol.com>
> Date: Thu, March 30, 2017 8:04 am
> To: [redacted] <[redacted]sunnyshulkin.com>, [redacted] <[redacted]@sunnyshulkin.com>, [redacted]n@gmail.com>
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** [redacted] <[redacted]gmail.com>
> > **Date:** March 30, 2017 at 5:29:19 AM CDT
> > **To:** drshulkin@aol.com
> > **Subject: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR**
> >
> > VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR
> >
> > http://www.npr.org/sections/health-shots/2017/03/30/521937557/the-va-is-on-a-path-toward-recovery-secretary-of-veterans-affairs-says

AMERICAN OVERSIGHT

Message

From: [redacted]sunnyshulkin.com [[redacted]sunnyshulkin.com]
Sent: 3/30/2017 12:07:28 PM
To: David shulkin [Drshulkin@aol.com]
Subject: RE: Fwd: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

Great news! Love, [redacted]

-------- Original Message --------
Subject: Fwd: VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR
From: David shulkin <Drshulkin@aol.com>
Date: Thu, March 30, 2017 8:04 am
To: [redacted] <[redacted]sunnyshulkin.com>, [redacted] <mark@sunnyshulkin.com>, NedrA <nedrafetterman@gmail.com>

Sent from my iPhone

Begin forwarded message:

From: [redacted] <[redacted]gmail.com>
Date: March 30, 2017 at 5:29:19 AM CDT
To: drshulkin@aol.com
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VA Is On A Path Toward Recovery, Secretary Of Veterans Affairs Says : Shots - Health News : NPR

http://www.npr.org/sections/health-shots/2017/03/30/521937557/the-va-is-on-a-path-toward-recovery-secretary-of-veterans-affairs-says

AMERICAN OVERSIGHT

Message

From: Jared Kushner [(b) (6) (b) (6)
Sent: 3/30/2017 2:59:22 AM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Notes

I am very (b) (5)

On 3/29/17, 3:00 PM, "David shulkin" <Drshulkin@aol.com> wrote:

Ike- below are notes from the meeting today as recorded by our team- Jared was great and just pushed hard to get things done- that was a big help. We made good progress.

David
>
>
> 1. Telehealth EO (Should be a done deal, will need to work with (b) (6) and (b) (6) on timing but think that it will happen quickly)
> 2. Heard that there would be an EO close hold coming out in the next week to exempt technology from the hiring freeze which includes USDS. Will also say there is a need for a national technology council that reports to the president. VA Secretary will be apart of that council.
> 3. Our approach with Apple should be 3 prongs)1. Enable veterans to download their health records anywhere, work off blue button initiative 2.) incorporate health data from fit bits, watches etc into the health record 3.) make sure clinicians have appropriate access to the technology. The next step is for (b) (6) to convene the va group and apple group together.
> 4. Secretary was shown 4 CIO resumes, he liked 3. The WH recruiting team will be doing a technical and background review on all the 3 and see who be best to come in for an interview(here are the names (b) (6) Chris Ross -CIO Mayo, (b) (6) Vet went to West Point and (b) (6)
> 5. DOD and VA meeting went well. Next step is for the two teams to look at analysis if VA can piggy back on the contract and how much would that cost, is it feasible. Follow up meeting should be next week in preparation for the DOD Mattis meeting on 4/12. Looking for least amount of money and quickest win.
> 6. Shared the EO for Accountability and Whistleblower, need to send electronic copy to (b) (6)
>
>

AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 3/29/2017 7:40:01 PM
To: David shulkin [Drshulkin@aol.com]
CC: Ike Perlmutter [(b) (6) frenchangel59.com]
Subject: Re: Notes

Thank you great progress. There is a lot of technology out there that would be free and assist with the positive interaction between the DOD and the VA when it comes to tracking military health prior to coming into VA system.

Sent from my iPad
Bruce Moskowitz M.D.

> On Mar 29, 2017, at 3:00 PM, David shulkin <Drshulkin@aol.com> wrote:
>
>
>
> Ike- below are notes from the meeting today as recorded by our team- Jared was great and just pushed hard to get things done- that was a big help. We made good progress.
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> David
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>>
>>
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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/29/2017 7:00:49 PM
To: Ike Perlmutter [(b) (6)frenchangel59.com]
CC: Bruce Moskowitz [(b) (6) mac.com]
BCC: Jared Kushner [(b) (6) (b) (6)
Subject: Fwd: Notes

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>
>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 1:33:06 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Fwd: VA Video

Please send to tom murphy-

Can we discuss at report in the am?

> You may want to look at this in case it gets picked up -
> https://www.youtube.com/watch?v=FQ4bdPnf7YI
>
> Only vice news has reported on it so far

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/30/2017 9:06:44 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fwd: VA Video

Between our boys we are sure of stuff hitting us- you maybe aware of this but a heads up

Sent from my iPhone

Begin forwarded message:

> **From:** <(b) (6) yahoo.com>
> **Date:** March 30, 2017 at 9:52:28 PM GMT+1
> **To:** Poonam Alaigh <(b) (6) hotmail.com>
> **Subject: VA Video**
>
> You may want to look at this in case it gets picked up -
> https://www.youtube.com/watch?v=FQ4bdPnf7YI
>
> Only vice news has reported on it so far

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 4/5/2017 3:04:41 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; IP [(b) (6) frenchangel59.com]; L Perl [(b) (6) gmail.com]; mbs(b) (6) @gmail.com
Subject: Re: VA families

Perfect

Sent from my iPhone

> On Apr 5, 2017, at 10:36 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>
> I have a meeting with the Hopkins group that developed emocha at noon. Some of their solutions may help with the opioid addiction problem. My colleagues at the medical centers have been extraordinarily generous in pointing me to technology even though it may be from another competing center unrelated to the group of five. If I feel the technology is of importance I will pass it on and then perhaps if you also believe it advances health care we should go forward since you are in the best position to determine if it has merit to your mission.
>
> Sent from my iPad
> Bruce Moskowitz M.D.
>
>> On Apr 5, 2017, at 10:01 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>>
>> Sounds good- lets add this to the agenda for our discussion tomorrow. Please feel free to add anything additional that I may have missed
>>
>> Agenda
>>
>> 1) R&D and licensing opportunity- will introduce you to Dr (b) (6)
>>
>> 2) expanding/funding for VA focused residency slots
>>
>> 3) follow up on the VCL hearing
>>
>> 4) transparency website and our Academic Affiliate group
>>
>> Sent from my iPhone
>>
>>> On Apr 5, 2017, at 9:16 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>>
>>> I can coordinate I probably should talk with one of your group which was at the committee hearing
>>>
>>> Sent from my iPhone
>>>
>>>> On Apr 5, 2017, at 9:01 AM, David shulkin <Drshulkin@aol.com> wrote:
>>>>
>>>> That would be great Bruce- do you need us to do anything at this point?
>>>>
>>>> Sent from my iPhone
>>>>
>>>>> On Apr 5, 2017, at 7:51 AM, Bruce Moskowitz <(b) (6) mac.com> wrote:
>>>>>
>>>>> After the Congressional testimony yesterday by a female Veteran I believe we can show the congressional committee and Veterans the partnership with the Academic Centers can advance care at the time the issue is raised. In order to do this we should have a mechanism of defining the issue and then asking which of the partners has a platform to solve the issue. In the case raised yesterday it would be two of our partners, Mayo Clinic and Brigham and Women's. The ability to "pull things off the shelf" immediately shows the value of a partnership arrangement.
>>>>>
>>>>> Sent from my iPad
>>>>> Bruce Moskowitz M.D.
>>>>

AMERICAN OVERSIGHT

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From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/5/2017 2:36:33 PM
To: David Shulkin [drshulkin@aol.com]; Poonam Alaigh [(b) (6) hotmail.com]
CC: IP [(b) (6) frenchangel59.com]; L Perl [(b) (6) gmail.com]; (b) (6) gmail.com
Subject: Re: VA families

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AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 4/5/2017 2:01:49 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: David shulkin [Drshulkin@aol.com]; L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; (b) (6) gmail.com
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AMERICAN OVERSIGHT

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Sent: 4/5/2017 1:01:03 PM
To: Bruce Moskowitz [(b) (6) mac.com]
CC: Poonam Alaigh [(b) (6) hotmail.com]; L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; mbs(b) (6) @gmail.com
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AMERICAN OVERSIGHT

Message

From: Bruce Moskowitz [(b) (6) mac.com]
Sent: 4/5/2017 11:51:09 AM
To: drshulkin@aol.com; Poonam Alaigh [(b) (6) hotmail.com]
CC: L Perl [(b) (6) gmail.com]; IP [(b) (6) frenchangel59.com]; mbs(b) (6) @gmail.com
Subject: VA families

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Sent from my iPad
Bruce Moskowitz M.D.

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/26/2017 3:08:02 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Fw: J&J VHA Recommendations 24Mar17
Attachments: JnJ VHA Recommendataions 24MAR17_final-2.pdf

see attached J&J presentation

From: (b) (6) <(b) (6) va.gov>
Sent: Friday, March 24, 2017 1:37 PM
To: '(b) (6) its.jnj.com'; '(b) (6) [JRDUS]'; (b) (6) (b) (6) (b) (6) Ramoni, Rachel; Valentino, Michael (VACO); (b) (6) (NOLA); Carroll, David (VACO); (b) (6) (b) (6) (Portland); (b) (6) DURVAMC; (b) (6) (b) (6) (PBM); (b) (6) Pape, Lisa M.; Lynch, Thomas (VHA); (b) (6) [JJCUS]; (b) (6) (b) (6) ITS.JNJ.com'; '(b) (6) its.jnj.com'; (b) (6) ITS.JNJ.com'; (b) (6) ITS.JNJ.com'; (b) (6) MD, MPH; (b) (6) Poonam Alaigh
Subject: FW: J&J VHA Recommendations 24Mar17

Attached is the presentation for this afternoon

(b) (6)
Staff Assistant

Office of the Under Secretary for Health

Veterans Health Administration

202-461-(b) (6) (Office)

202-823-(b) (6) (Mobile)

Meeting requests: VHAUSHMeetingRequests@va.gov

From: (b) (6) [DPYUS] [mailto(b) (6) ITS.JNJ.com]
Sent: Friday, March 24, 2017 1:30 PM
To: Alaigh, Poonam, M.D.; (b) (6) (b) (6)
Subject: [EXTERNAL] J&J VHA Recommendations 24Mar17

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Please see attached presentation.

Thanks,

(b) (6) [redacted]

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Healthy Heroes Project

Recommendations for VHA Leadership

March 24, 2017

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The concepts in this presentation represent an accelerated set of ideas and proposals developed for discussion, feedback, and alignment. They are the result of an early stage of a process of envisioning a new working relationship between the pharmaceutical industry, academic affiliates and the Veterans Health Administration. It is not to be construed as a final proposal or a memorandum of understanding.

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Johnson & Johnson and the Veterans Health Administration partner to engage the nation to *reduce veteran suicides to zero*. We are aligning on high impact initiatives which accelerate improved outcomes with a focus on precision medicine, a direct to consumer integrated marketing campaign, and clinical trials and research studies.

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The Framework







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Our 10 Point Plan

1 Month

(b) (4), (b) (5)

3 Months

(b) (4), (b) (5)

6 Months

(b) (4), (b) (5)

9 Months

(b) (4), (b) (5)

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Precision Medicine

AMERICAN OVERSIGHT

Precision Medicine

Bottom Line Up Front

(b) (4), (b) (5) [redacted]

The goals will be to:

- (b) (4), (b) (5) [redacted]

These advances will require:

- (b) (4), (b) (5) [redacted]

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Precision Medicine Scope:

(b) (4), (b) (5)

[redacted]

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Scalable Predictive Platform: Key Considerations

- (b) (4), (b) (5)
- [redacted]

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Strengths that we each bring to the table

Veterans Health Administration

Johnson & Johnson

(b) (4), (b) (5)



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Precision Medicine: Quick Wins (~ 9 months)

predictive platform v1: 'Focus on extant data and 'THE WHO"



- (b) (4), (b) (5) [redacted]

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Precision Medicine: Phase I (~ 20 months)

predictive platform v2: 'Focus on new data and THE WHEN'

(b) (4), (b) (5)

[redacted]

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Precision Medicine Phase II
(~ 42 Months and beyond)

- (b) (4), (b) (5)
- [redacted]

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Clinical Trials & Research Studies

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Executive Summary

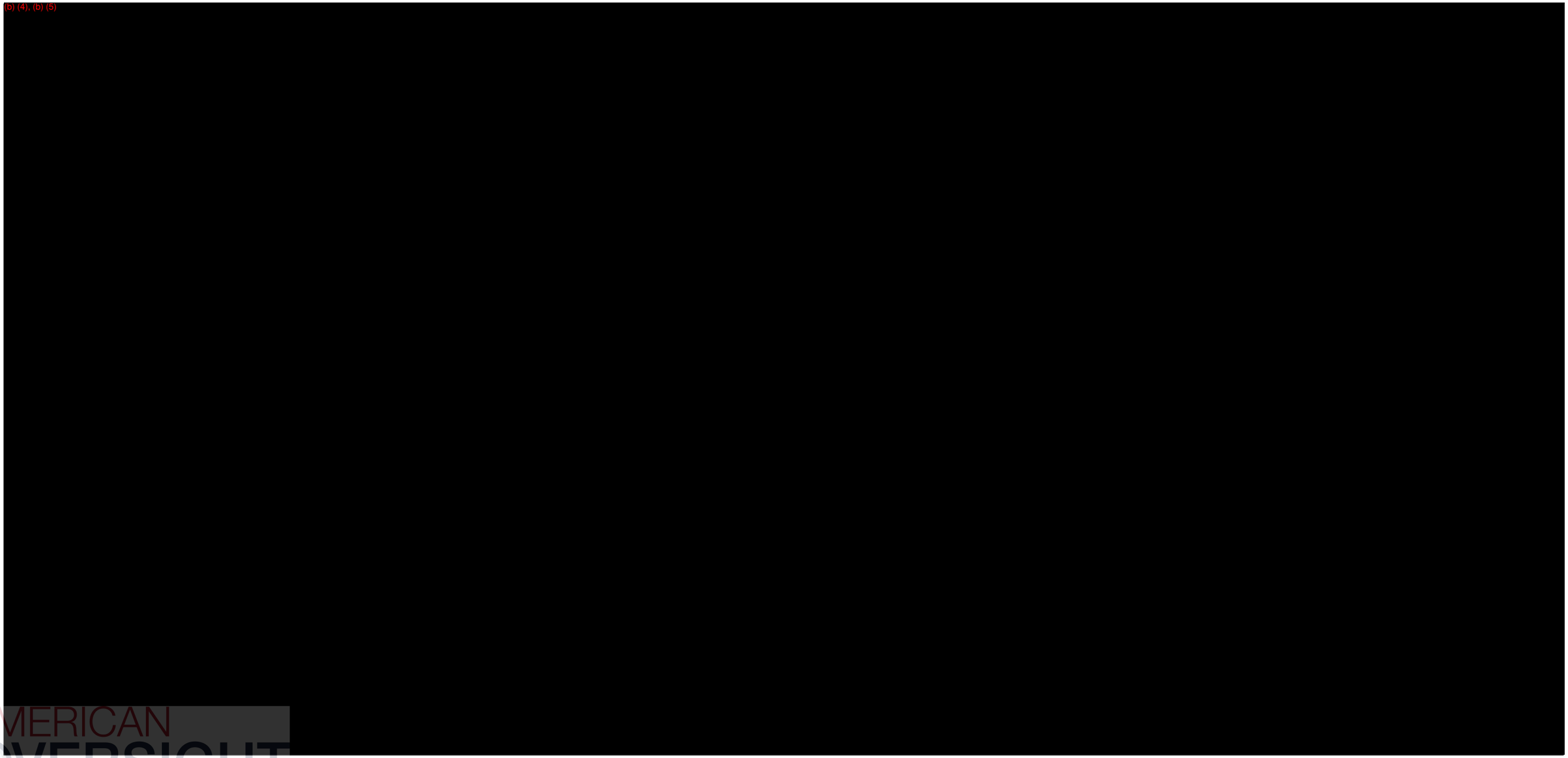
Bottom Line Up Front

- (b) (4), (b) (5) [redacted]

AMERICAN OVERSIGHT

Summary of Proposals

(b) (4), (b) (5)



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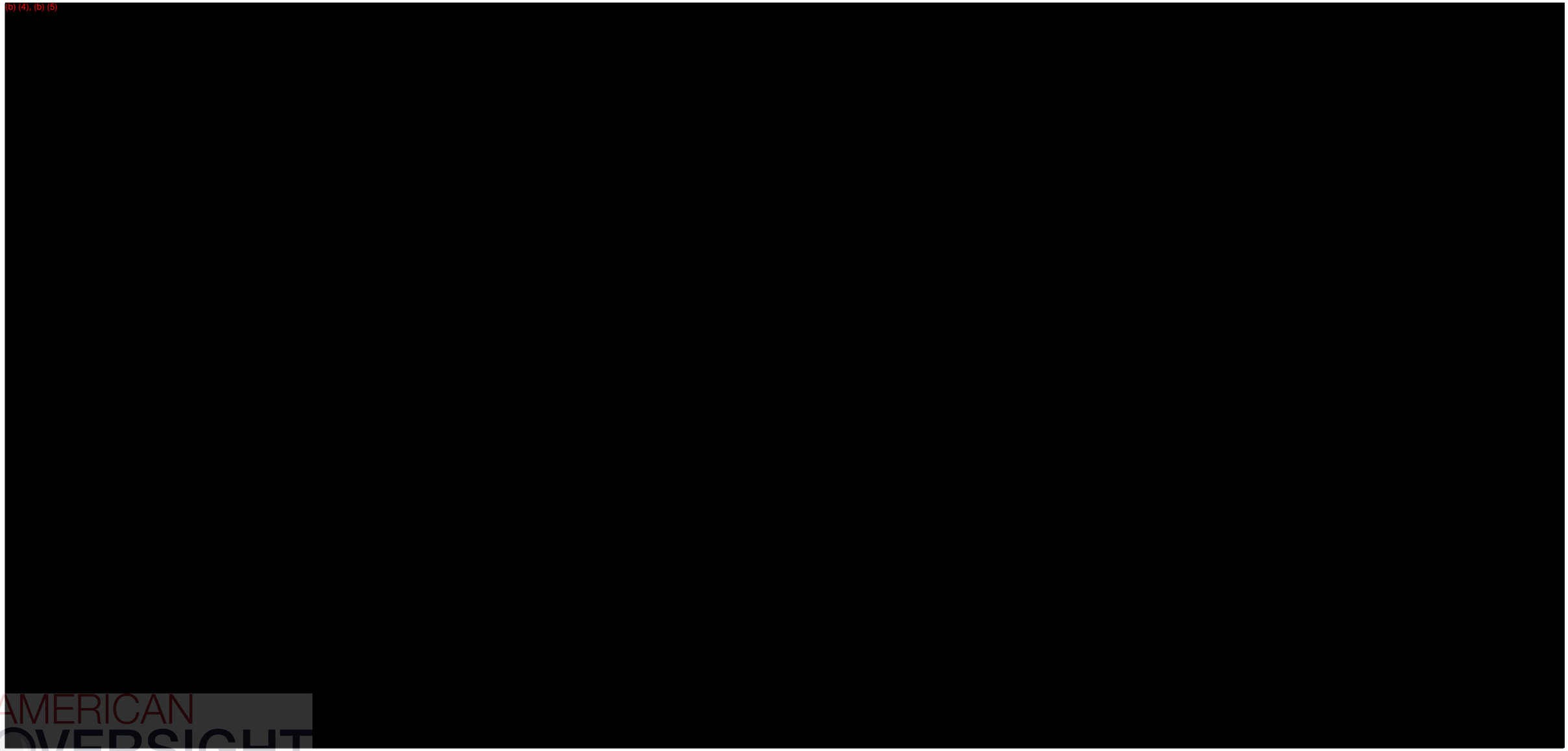
Summary of Proposals *(cont.)*

(b) (4), (b) (5)



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Next Steps

- (b) (4), (b) (5) [redacted]

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Getting to Zero: Preventing Veteran Suicide is Everyone's Responsibility

INTEGRATED MARKETING CAMPAIGN

AMERICAN OVERSIGHT

Johnson & Johnson

Integrated Marketing Campaign

Bottom Line Up Front

Goal	Insight	Strategic Approach	Outcome
(b) (4), (b) (5)			

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The Situation

20

veterans a day die by suicide

14

are not engaged in VA healthcare at the time of death

(b) (4), (b) (5)

[redacted]

(b) (4), (b) (5)

[redacted]

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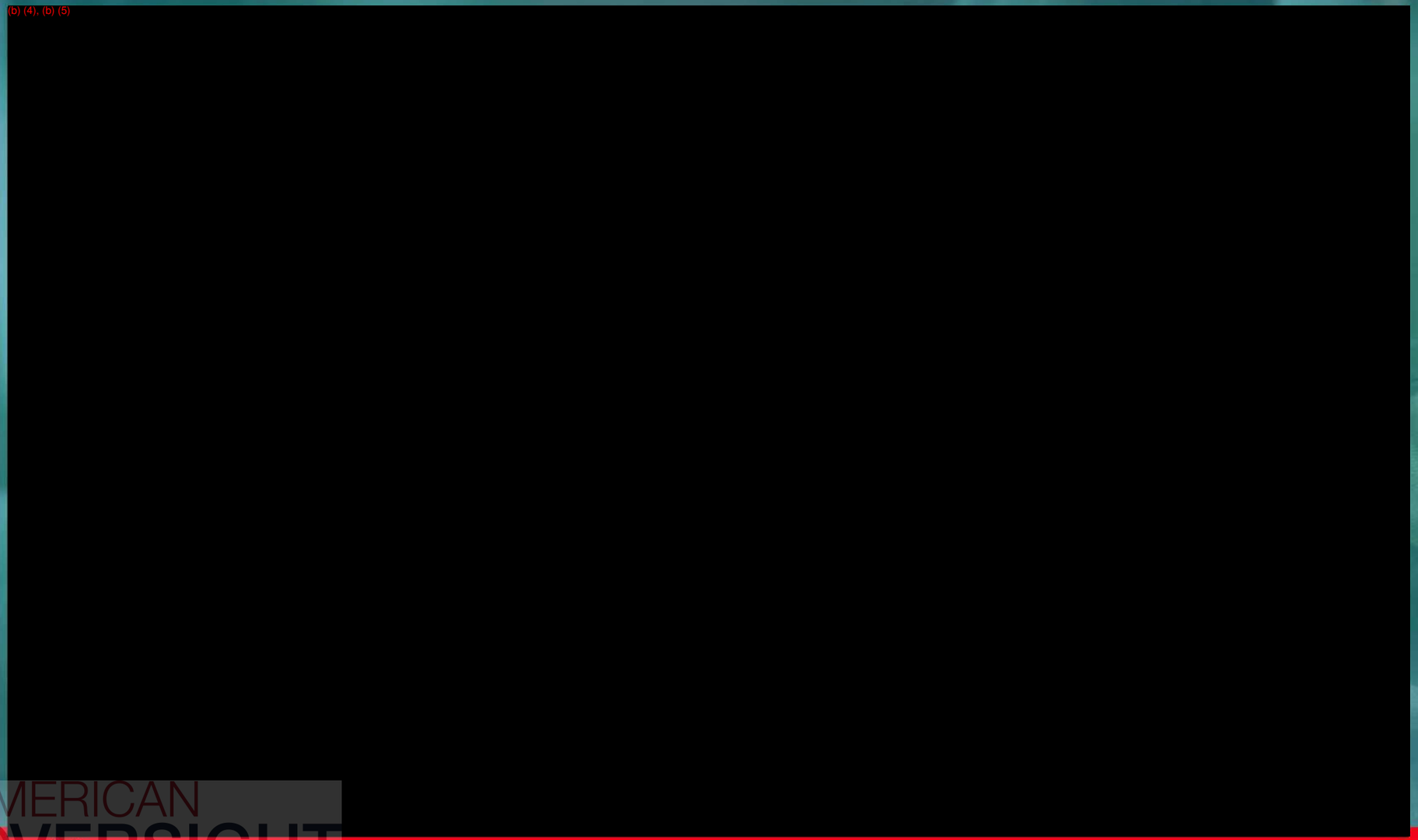
The Emotional Imperative

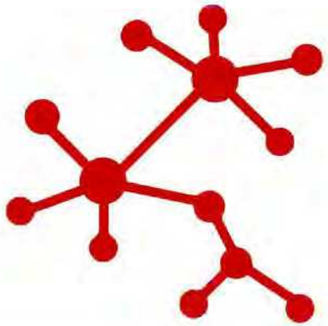
(b) (4), (b) (5)



AMERICAN OVERSIGHT

Strategic Approach

Connecting communities to veterans and veterans to care







(b) (4), (b) (5)

[redacted]

AMERICAN OVERSIGHT

Focus Influence and Reach of Leading Organizations Around Single Strategic Mission

(b) (4), (b) (5)



AMERICAN OVERSIGHT

Spark a National Movement

(b) (4), (b) (5)

[redacted]

AMERICAN OVERSIGHT

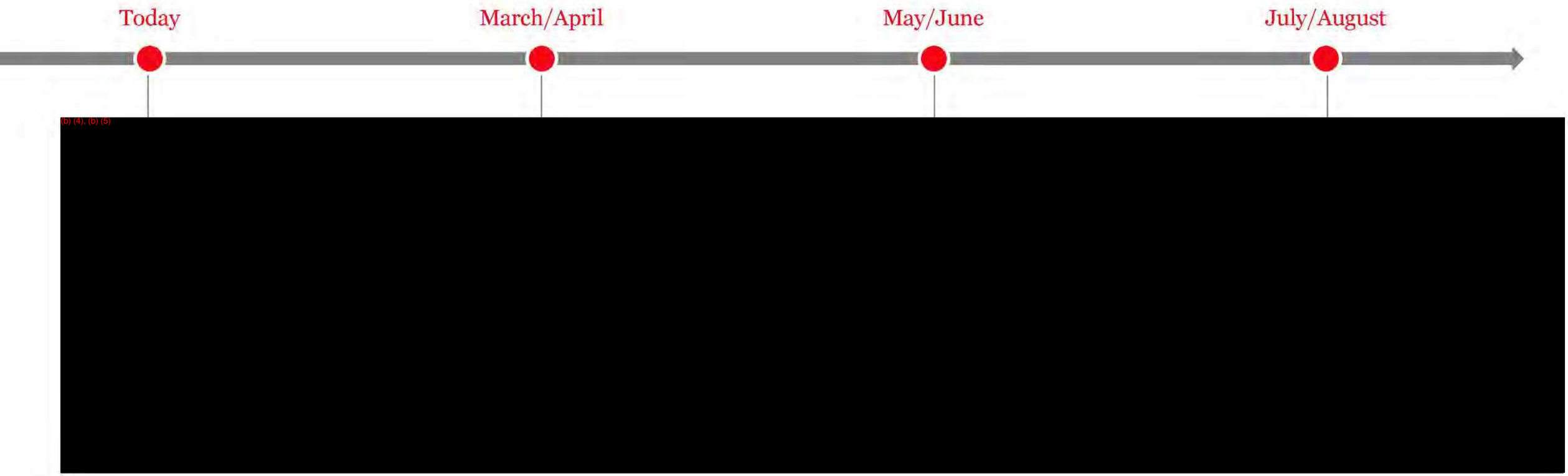
Unprecedented Connections

(b) (4), (b) (5)



AMERICAN OVERSIGHT

Next Steps



AMERICAN OVERSIGHT

Veterans Health Administration

&

Johnson & Johnson

AMERICAN OVERSIGHT

Backup

AMERICAN OVERSIGHT

Human Performance Institute

Immersion Training & Train the Trainer Programs

Johnson & Johnson HUMAN PERFORMANCE INSTITUTE

(b) (4), (b) (5)

[redacted]

AMERICAN OVERSIGHT

Human Performance Institute

Digital Coaching: Skills for Life

Johnson & Johnson HUMAN PERFORMANCE INSTITUTE®

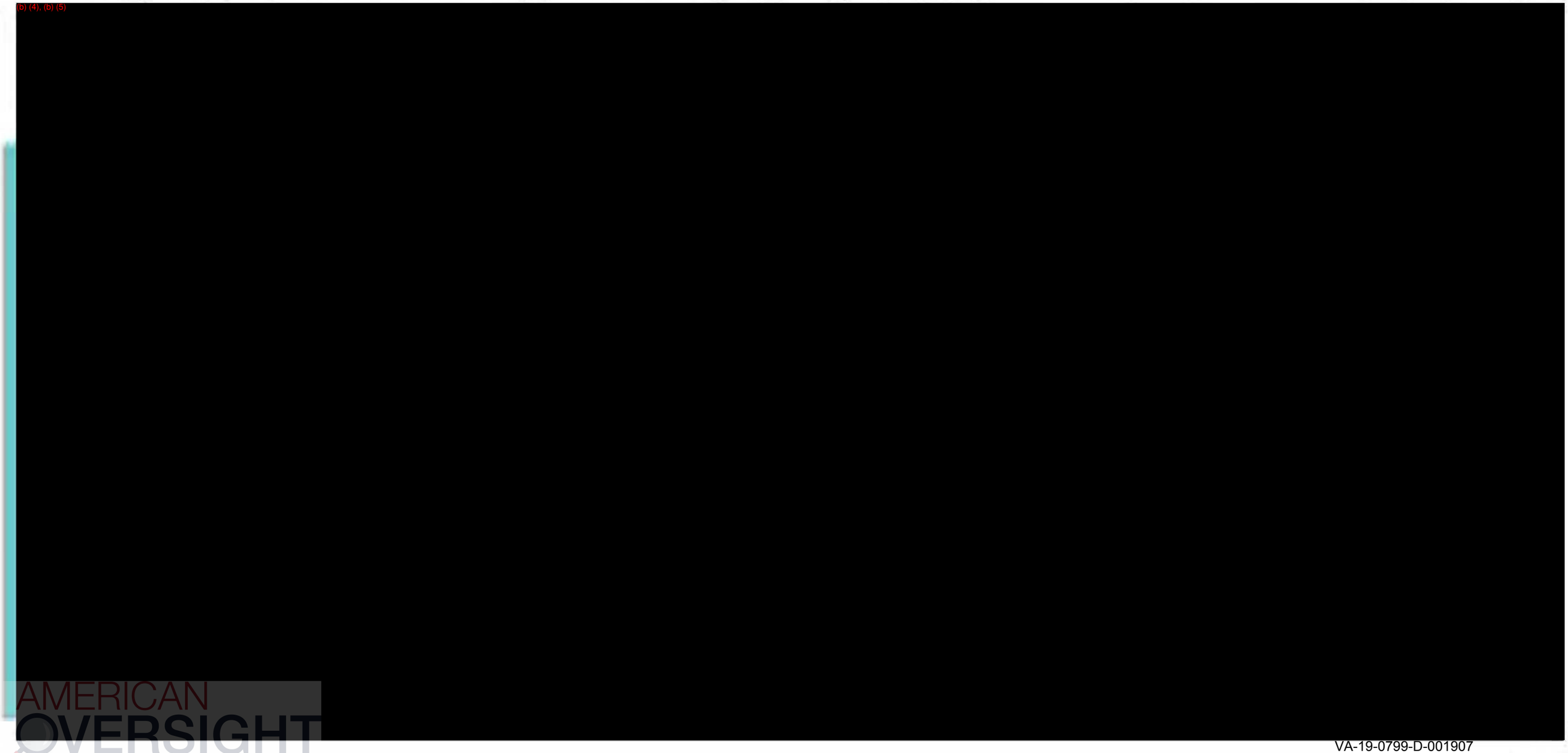
(b) (4), (b) (5)



AMERICAN OVERSIGHT

Digital Health: My Study Reporter

(b) (4), (b) (5)



AMERICAN OVERSIGHT

Digital Health: My Study Reporter

(b) (4), (b) (5)



AMERICAN OVERSIGHT

Digital Health: SIBAT

(b) (4), (b) (5)

- [redacted]
- [redacted]
- [redacted]

AMERICAN OVERSIGHT

Adopt SPOC center at the central research office for all VHA clinical trials

(b) (4), (b) (5)

[redacted]

AMERICAN OVERSIGHT

Adopt single point of contact within the central research office for all VHA clinical trials

- (b) (4), (b) (5)

AMERICAN OVERSIGHT

(b) (4), (b) (5)

[redacted] Clinical Trial Cooperative Research & Development Agreement (CRADA)



Background considerations

- (b) (4), (b) (5) [redacted]

AMERICAN OVERSIGHT

(b) (4), (b) (5) (b) (4), (b) (5) Clinical Trial

Cooperative Research & Development Agreement (CRADA) *(continued)*



- (b) (4), (b) (5)

AMERICAN OVERSIGHT

(b) (4), (b) (5)

Clinical Trial Cooperative Research & Development Agreement (CRADA) *(continued)*

(b) (4), (b) (5)

- [redacted]

AMERICAN OVERSIGHT

Update Publications and other terms that cause

(b) (4), (b) (5)

[redacted]

AMERICAN OVERSIGHT

Communicate VHA capabilities and establish ongoing dialog with companies conducting research

- Key Messages
- Timing
- Key Partners

(b) (4), (b) (5)

[redacted]

AMERICAN OVERSIGHT

Communicate VHA capabilities and establish ongoing dialog with companies conducting research

(b) (4), (b) (5)



AMERICAN OVERSIGHT

Johnson & Johnson

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 3/26/2017 12:45:33 PM
To: (b) (6) hotmail.com
Subject: Re: Commission

I just appointed the commission members on Friday.

I never heard that about the acting role- we need to check on that (I will do that)- does not make sense to me as (b) (6) was an active candidate when I was up for USH- but if its recent we need to be sure.

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: David Shulkin <drshulkin@aol.com>
Sent: Sun, Mar 26, 2017 8:03 am
Subject: Commission

Any update on that? The 4 corners were asking about it and I told them that I did not know the status. Also, heard that the nominated person could not be in an acting role based on a recent ruling

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/26/2017 12:03:22 PM
To: David Shulkin [drshulkin@aol.com]
Subject: Commission

Any update on that? The 4 corners were asking about it and I told them that I did not know the status. Also, heard that the nominated person could not be in an acting role based on a recent ruling

Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 3/26/2017 12:43:53 PM
To: (b) (6) hotmail.com
Subject: Re: Document - FROM VA - Donna Katen-Bahensky

ok thanks

-----Original Message-----
From: Poonam Alaigh <(b) (6) hotmail.com>
To: David shulkin <Drshulkin@aol.com>
Sent: Sun, Mar 26, 2017 8:39 am
Subject: Re: Document - FROM VA - Donna Katen-Bahensky

It's not the content that I am concerned about but her action- will fill you in more about my concerns though harmless right now, we need to manage

Sent from my iPhone

On Mar 26, 2017, at 8:36 AM, David shulkin <Drshulkin@aol.com> wrote:

> I think she made her content harmless
>
> We can discuss more monday
>
> Sent from my iPhone
>
> On Mar 26, 2017, at 7:53 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> > Not good judgement on Donna's part- with all her experience in the private sector, and apparently a "seasoned executive", she should've known better
> >
> > Sent from my iPhone
> >
> > On Mar 25, 2017, at 10:51 PM, David Shulkin <drshulkin@aol.com> wrote:
> >
> > > Ike sent to me
> > >
> > > Sent from my iPad
> > >
> > > On Mar 25, 2017, at 10:05 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
> > >
> > > > How did you get this - did she include you in her correspondence with Ike
> > > >
> > > > Sent from my iPhone
> > > >
> > > > On Mar 25, 2017, at 8:20 PM, David Shulkin <drshulkin@aol.com> wrote:
> > > >
> > > > > This is what the west palm beach medical center director sent to Ike. Nothing too surprising but wanted you to see. I told her she was free to respond to his inquiries.

AMERICAN OVERSIGHT

Dear Marisol
Thank you for the call today. I have attached the draft document and can certainly provide more detail if you or Mr. P would like more information. Looking forward to improving the Veteran's care with the two of you
Sincerely
Donna Katen-Bahensky
donna.katen-bahensky@va.gov

<Veteran Centric VA.docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/26/2017 12:39:55 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: Document - FROM VA - Donna Katen-Bahensky

It's not the content that I am concerned about but her action- will fill you in more about my concerns though harmless right now, we need to manage

Sent from my iPhone

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AMERICAN OVERSIGHT

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donna.katen-bahensky@va.gov

<Veteran Centric VA.docx>

AMERICAN OVERSIGHT

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From: David shulkin [Drshulkin@aol.com]
Sent: 3/26/2017 12:36:14 PM
To: Poonam Alaigh [(b) (6) hotmail.com]
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AMERICAN OVERSIGHT

<Veteran Centric VA.docx>

AMERICAN OVERSIGHT

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From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/26/2017 11:53:14 AM
To: David Shulkin [drshulkin@aol.com]
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Sent from my iPhone

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> > > Donna Katen-Bahensky
> > > donna.katen-bahensky@va.gov
> > >
> > > <Veteran Centric VA.docx>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 3/26/2017 2:51:16 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: Document - FROM VA - Donna Katen-Bahensky

Ike sent to me

Sent from my iPad

On Mar 25, 2017, at 10:05 PM, Poonam Alaigh <(b) (6) hotmail.com> wrote:

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> >
> > <Veteran Centric VA.docx>

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/26/2017 2:05:02 AM
To: David Shulkin [drshulkin@aol.com]
Subject: Re: Document - FROM VA - Donna Katen-Bahensky

How did you get this - did she include you in her correspondence with Ike

Sent from my iPhone

On Mar 25, 2017, at 8:20 PM, David Shulkin <drshulkin@aol.com> wrote:

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> donna.katen-bahensky@va.gov
>
> <Veteran Centric VA.docx>

AMERICAN OVERSIGHT

Message

From: David Shulkin [drshulkin@aol.com]
Sent: 3/26/2017 12:20:16 AM
To: (b) (6) hotmail.com
Subject: Fwd: Document - FROM VA - Donna Katen-Bahensky
Attachments: Veteran Centric VA.docx

This is what the west palm beach medical center director sent to Ike.
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donna.katen-bahensky@va.gov

AMERICAN OVERSIGHT

Let's Make the VA more Veteran-Centric

When asked what could be done to make the VA system more Veteran-Centric, we realized it is impossible to consider only one priority. There are multiple factors and several can be found in the Commission on Care report-this report was developed by some of the most reputable leaders in health care across the United States.

"The most public and glaring deficiency was access problems". Much work has been done and improvements have bene made but access remains a high priority. The Commission went further in writing the following, "…the long term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities, and procurement." We at West Palm Beach VA believe the Veteran experience of care is most influential attribute that will determine the future relevance of VHA.

With the report's recommendations and observation at the West Palm Beach VA, we have developed the following set of priorities under four themes:

1) Recruitment, retention, compensation and talent management remain concerns for VHA. Dated standards and rigid hiring practices result in substantial delays and restrict the ability to incorporate cultural fit and customer service as critical metrics in the hiring process. This oftentimes leads to investment in staff that does not possess core values that align with VA mission. The current compensation and talent management systems do not support local growth, hindering the development of a stable leadership team. As stated in the Commission on Care Report, a system that allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade); promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits; and establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement, would create a foundation for strength in leadership and management at all levels. Conversely, having the ability to discipline and remove those who do not possess ICARE core values, is integral to maintaining and managing a highly functional workforce. **Start with the Right Staff with the Right Attitude and Focus on Accountability.**

2) Providing the Right Environment and the Right Technology Tools. Modernization of physical and technological infrastructure. Investment in capital-asset needs and information technology is required to operate efficiently and effectively. In order to meet the needs of Veterans, access to state-of-the-art healthcare is required. Location of services in spaces accessible and convenient for Veterans. **As an example, forward thinking initiatives using available technology, such as iPads for delivery of care to Veterans and easy-to-use applications for scheduling appointments have been delayed due to stringent security policies that hinder the ability to meet the needs and preferences of patients.**

AMERICAN OVERSIGHT

3) Strengthening Community Partnerships. Strengthening community partnerships to provide an integrated and holistic approach for Veteran well-being; establishment of networks to provide access to community support for at-risk Veterans 24/7; **cultivation of resources for Veterans who struggle with housing challenges, substance abuse and employment; and tangible benefits for organizations who hire Veterans.**

4) Creating Integrated Networks. Harnessing the expertise of community healthcare organizations to develop the ultimate healthcare delivery system for Veterans, comprised of recognized programs with high-quality results. **The newest generation Veterans are eager to receive alternative therapies and treatment options to address both physical and psychological conditions—collaborative research programs and partnerships with highly regarded institutions will help to ensure the cutting edge care Veterans deserve.**

AMERICAN OVERSIGHT

Message

From: IP [(b) (6)frenchangel59.com]
Sent: 3/25/2017 10:09:02 PM
To: David shulkin [drshulkin@aol.com]
Subject: FW: Document - FROM VA - Donna Katen-Bahensky
Attachments: Veteran Centric VA.docx

FYI

From: Katen-Bahensky, Donna [mailto:Donna.Katen-Bahensky@va.gov]
Sent: Tuesday, March 21, 2017 10:57 PM
To: (b) (6)@frenchangel59.com
Subject: Document

Dear Marisol
Thank you for the call today. I have attached the draft document and can certainly provide more detail if you or Mr. P would like more information.
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Sincerely
Donna Katen-Bahensky
donna.katen-bahensky@va.gov

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/26/2017 12:03:23 AM
To: (b) (6) [(b) (6) gmail.com]
Subject: Re: 10 Priorities Slides

No

Sent from my iPhone

On Mar 25, 2017, at 7:56 PM, (b) (6) <(b) (6) gmail.com> wrote:

> For AAMC, Baligh is in Montana and (b) (6) is in leesburg. Do you want (b) (6) 's to attend with you -she's one of the new doctors on Baligh's team working in this area.
>
> On Mar 25, 2017 3:46 PM, "David shulkin" <Drshulkin@aol.com> wrote:
> Thanks
>
> Sent from my iPhone
>
> > On Mar 25, 2017, at 3:41 PM, (b) (6) <(b) (6) gmail.com> wrote:
> >
> > Pulled out the 10 priorities slides
> > (b) (6)
> > <10 priorities slides.pptx>

AMERICAN OVERSIGHT

Message

From: [redacted] [redacted]gmail.com]
Sent: 3/25/2017 11:56:08 PM
To: David shulkin [Drshulkin@aol.com]
Subject: Re: 10 Priorities Slides

For AAMC, Baligh is in Montana and [redacted] is in leesburg. Do you want Kameron Matthew's to attend with you -she's one of the new doctors on Baligh's team working in this area.

On Mar 25, 2017 3:46 PM, "David shulkin" <Drshulkin@aol.com> wrote:
Thanks

Sent from my iPhone

> On Mar 25, 2017, at 3:41 PM, [redacted] <[redacted]gmail.com> wrote:
>
> Pulled out the 10 priorities slides
> [redacted]
> <10 priorities slides.pptx>

AMERICAN OVERSIGHT

Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/25/2017 7:46:34 PM
To: (b) (6) [(b) (6) gmail.com]
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> (b) (6)
> <10 priorities slides.pptx>

AMERICAN OVERSIGHT

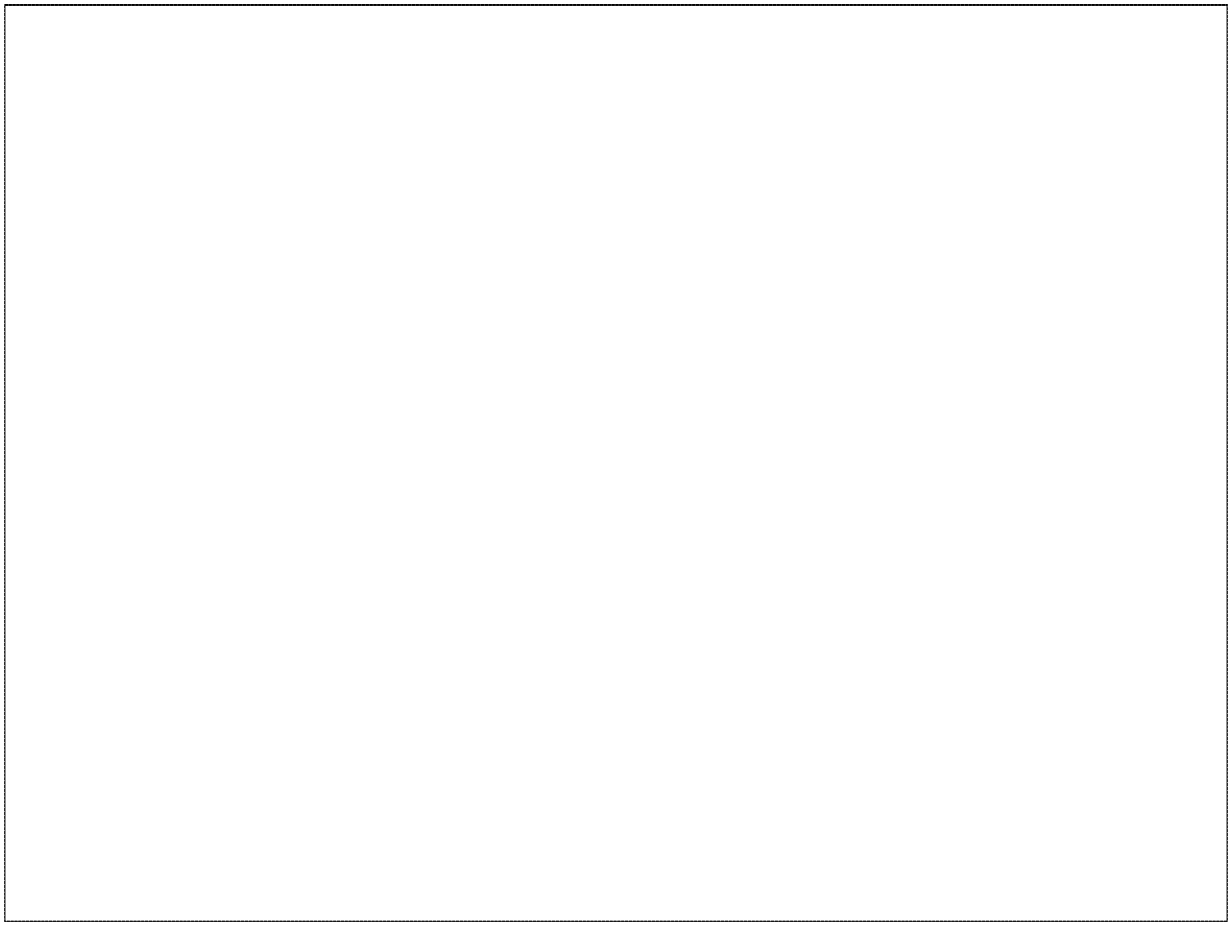
Message

From: [redacted] [redacted]gmail.com]
Sent: 3/25/2017 7:41:42 PM
To: David Shulkin [drshulkin@aol.com]
Subject: 10 Priorities Slides
Attachments: 10 priorities slides.pptx

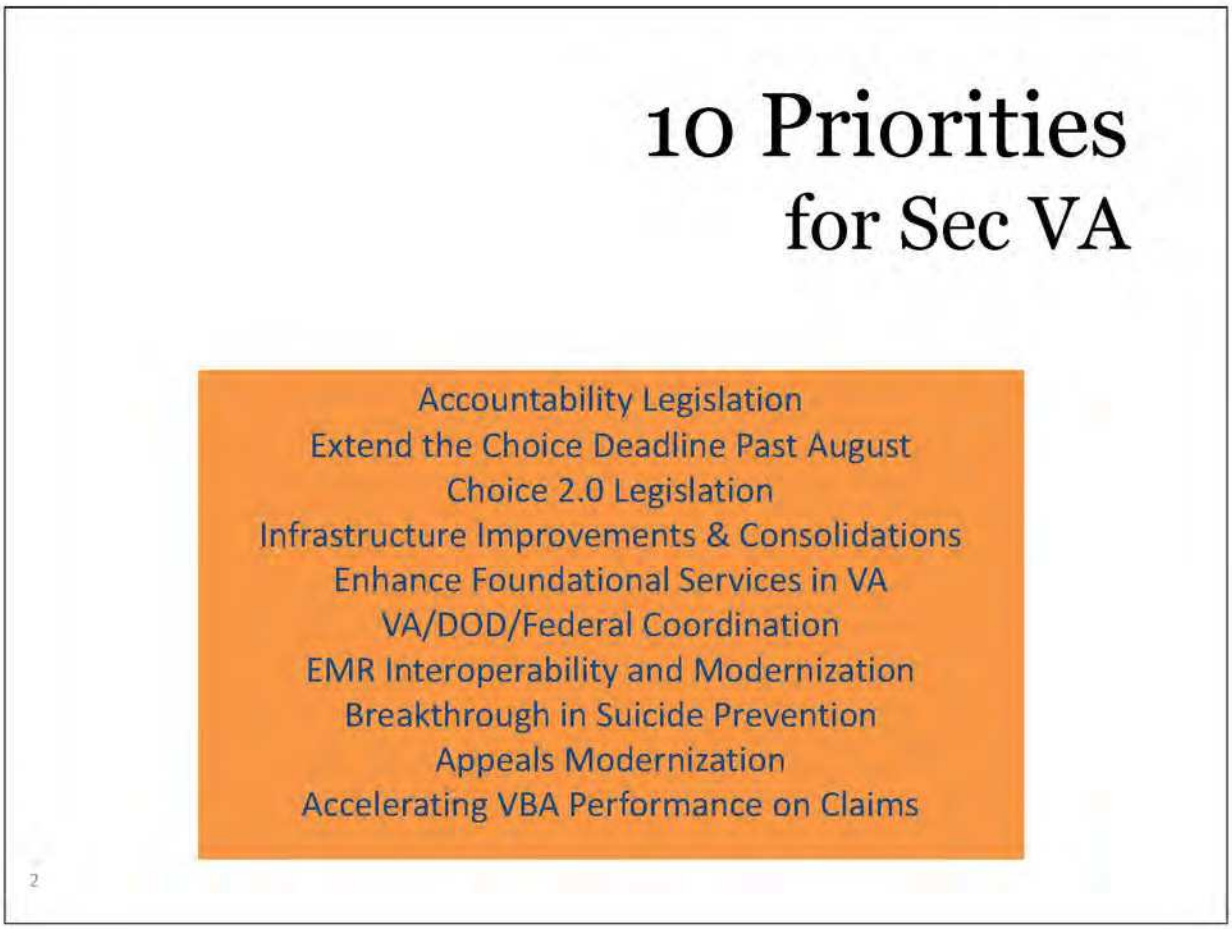
Pulled out the 10 priorities slides

[redacted]

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT



You might want to just read the list and then go on.

AMERICAN OVERSIGHT

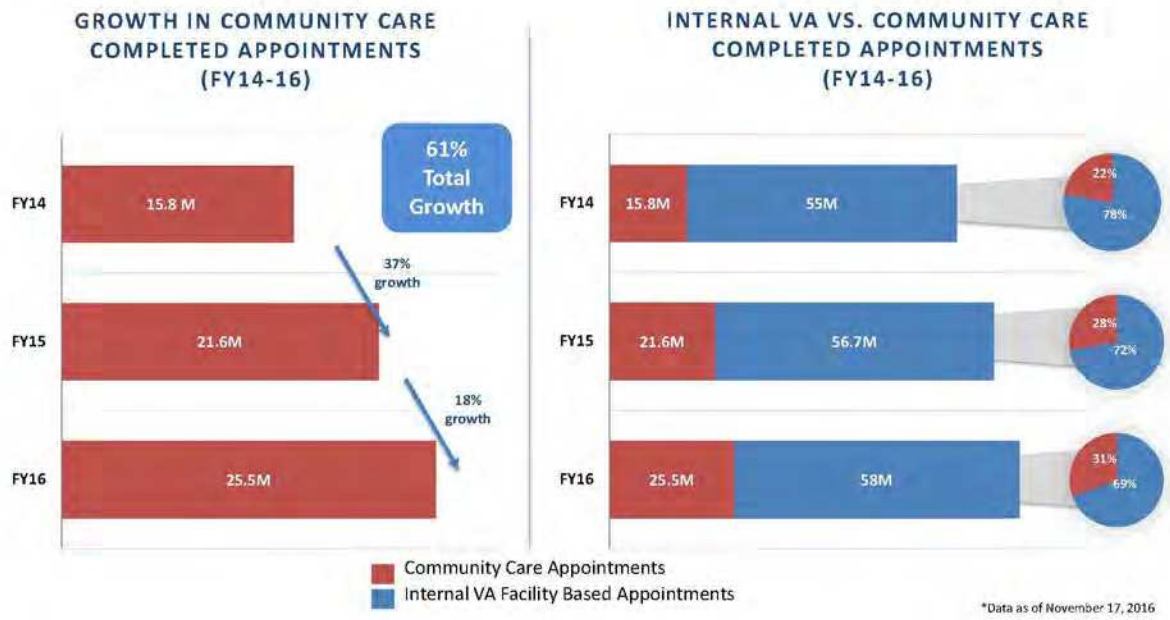
Accountability Legislation

1. **Increased flexibility to remove, demote, or suspend VA employees for poor performance or misconduct**
2. **Authority to recoup bonuses of employees for poor performance or misconduct**
3. **Authority to recoup relocation expenses authorized through fraud or malfeasance**
4. **Authority to reduce federal pensions for employees convicted of felonies**
5. **Increased protections for whistleblowers**

These bullet points are based on Chairman Roe's "VA Accountability First Act," introduced Feb. 28, 2017.

AMERICAN OVERSIGHT

Extend the Choice Deadline



4

AMERICAN OVERSIGHT

Choice 2.0 Legislation

1. Maintain a high-performing integrated network that includes VA, federal partners, academic affiliates, and community providers
2. Increase choice for all Veterans, starting with those with service-connected conditions
3. Ensure Veterans get the care they need, closer to home when appropriate
4. Optimize coordination of VA healthcare with the health insurance Veterans already have
5. Maintain affordability of healthcare options for low-income Veterans
6. Assist in coordinating care for Veterans served by multiple providers
7. Apply industry standards for performance, quality, patient satisfaction, payment models, and health outcomes

These are based on your recent HVAC testimony.

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Infrastructure Improvements



Officers' Quarters
Fort Thomas, KY
Circa 1895



Gas Station
Minneapolis, MN
1932

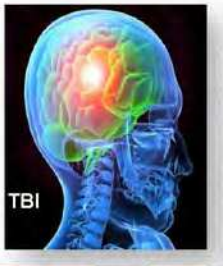


Palo Alto VAMC
2017

AMERICAN OVERSIGHT

Enhancing Foundational Services





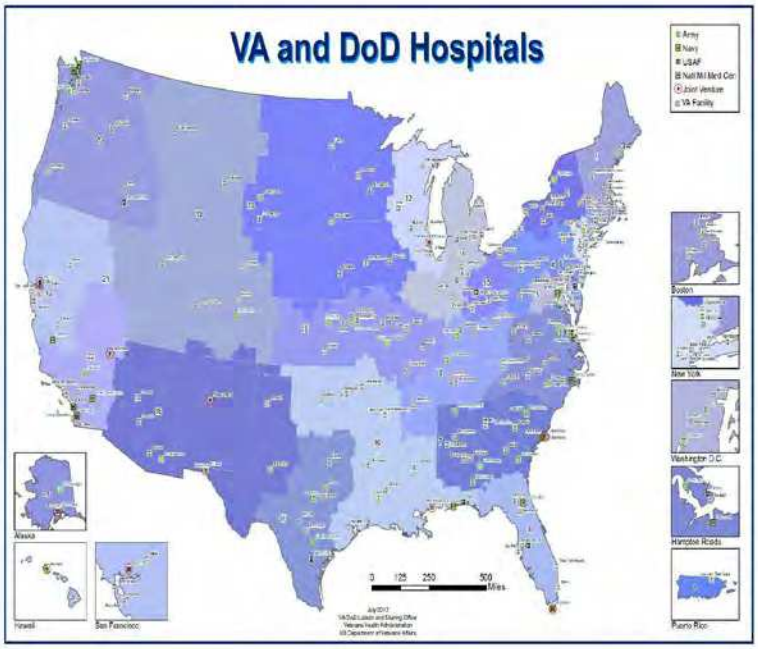






AMERICAN OVERSIGHT

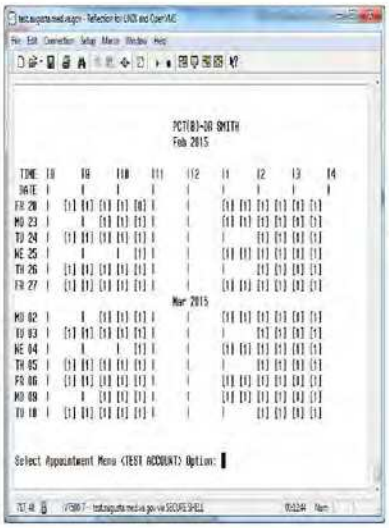
VA/DoD/Federal Coordination



8

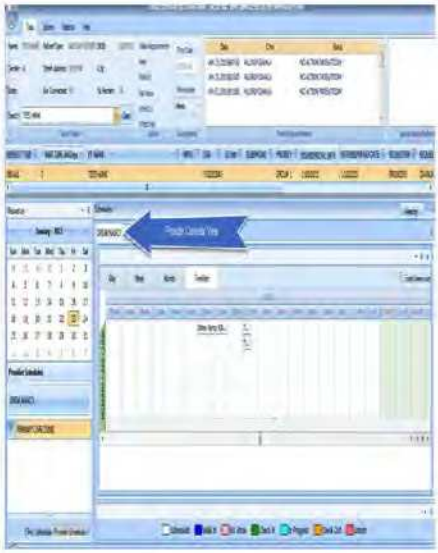
AMERICAN OVERSIGHT

EMR Interoperability & Modernization



VistA Legacy Scheduling

VistA Scheduling Enhancement



9

The point here is VistA was outdated (left), so we've made some improvements (right), but what we really need is a new system that's fully interoperable with what our partnering providers are already using.

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Suicide Prevention



10

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Mental Health PSA



11

The video will play as soon as you cue the next slide.

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Appeals Modernization



12

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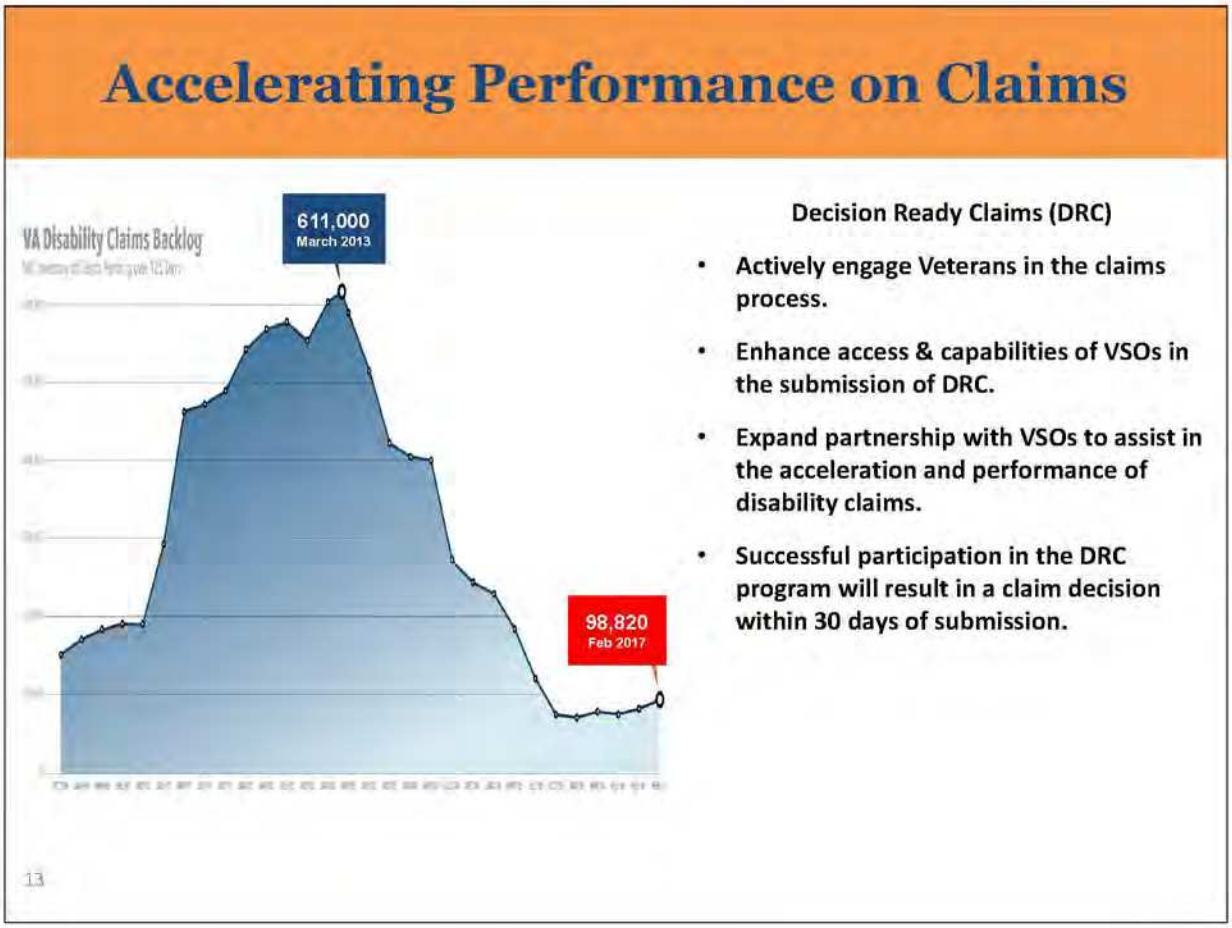

The bullets explain how the Decision Ready Claims program will improve performance, accelerate claims decisions, and further reduce the 125-day backlog. The program is slated to begin in May.

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Message

From: David shulkin [Drshulkin@aol.com]
Sent: 3/31/2017 10:38:13 AM
To: Poonam Alaigh [(b) (6) hotmail.com]
Subject: Re: John ullyot

Media and PR

Sent from my iPhone

> On Mar 31, 2017, at 5:33 AM, Poonam Alaigh <(b) (6) hotmail.com> wrote:
>
> What position is he getting - Asst secretary of what?
>
> Sent from my iPhone

AMERICAN OVERSIGHT

Message

From: Poonam Alaigh [(b) (6) hotmail.com]
Sent: 3/31/2017 9:33:50 AM
To: David Shulkin [drshulkin@aol.com]
Subject: John ullyot

What position is he getting - Asst secretary of what?

Sent from my iPhone

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